

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9782

## CERTIFICATE OF DEATH

09771

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Maryland</b>   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>   |  |  |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>  |  |   |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>   |  |  |  |
| c. LENGTH OF STAY IN 1b  |  |   |  | d. STREET ADDRESS <b>810 Spa Road</b>   |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>Anne Arundel General Hospital</b>   |  |   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>James</b> Middle <b>T.</b> Last <b>Adams</b>   |  |   |  | 4. DATE OF DEATH<br>Month <b>9</b> Day <b>19</b> Year <b>61</b>   |  |  |  |
| 5. SEX <b>Male</b>   |  | 6. COLOR OR RACE <b>Colored</b>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. AGE (in years last birthday) <b>58</b> yrs.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Laborer</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>Day</b>  |  | 8. DATE OF BIRTH <b>4/4/03</b>  |  | 11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>                        |  |
| 13. FATHER'S NAME <b>Harvey Adams</b>  |  | 14. MOTHER'S MAIDEN NAME <b>U. S. A.</b>  |  | 12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>  |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>                |  |
| 16. SOCIAL SECURITY NO. <b>220-16-4771</b>   |  | 17. INFORMANT <b>James T. Adams Box 218 Mechanicsville, Maryland</b>                                      |  | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Heart Block - Complete</b><br><b>420.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Myocardial Infarction</b><br>(c) <b>Arterio-sclerotic Cardiovascular Disease</b> |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>11 hours</b><br><b>undetermined</b><br><b>years</b> |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)  |  |   |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |  |   |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>9/22</b> , 19 <b>61</b> , to <b>9/29</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>9/29</b> , 19 <b>61</b> , and that death occurred at <b>4:15</b> P.M. from the causes and on the date stated above. |  |   |  |   |  |  |  |
| 22a. SIGNATURE <b>Faye W. Allen</b> M.D.   |  |   |  | 22b. DATE SIGNED <b>9/30/61</b>   |  |  |  |
| 22c. PHYSICIAN'S NAME (Type) <b>Faye W. Allen</b>  |  |   |  | 22d. ADDRESS <b>Cathedral Street, Annapolis, Maryland</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |  | 23b. DATE THEREOF <b>10/3/61</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Our Lady's Chapel</b>   |  | 23d. LOCATION (City, town or county) (State) <b>Leonardtown, Md.</b>                       |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley</b>   |  |   |  | 25a. REC'D BY REGISTRAR <b>OCT 4 '61</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60



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laborer day Maryland U. S. A.

Harvey Adams

220-16-771 James T. Adams Box 18 Mechanicsville, Maryland

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 9783 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09772

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FOR STATE  
HEALTH DEPT.

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TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

|   |  |  |  |   |  |   |  |   |  |
|---|--|--|--|---|--|---|--|---|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <b>Anne Arundel</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pasadena</b><br>c. LENGTH OF STAY IN 1b <b>13 days</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>11 Magnolia Ave.</b>   |  |  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution, residence before admission)<br>a. STATE <b>Ohio</b><br>b. COUNTY <b>East Liverpool</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>932 Florence Street</b><br>d. STREET ADDRESS |  |   |  |   |  |
| <b>3. NAME OF DECEASED</b> (Type or print) <b>Raymond Alfred Anders</b><br>First Middle Last  |  |  |  | <b>4. DATE OF DEATH</b> <b>September 21st. 19 61</b><br>Month Day Year  |  |   |  |   |  |
| <b>5. SEX</b><br>M W  |  | <b>6. COLOR OR RACE</b><br>M W   |  | <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | <b>8. DATE OF BIRTH</b> <b>4/4/11</b><br>yrs. |  | <b>9. AGE</b> (In years last birthday) <b>50</b> yrs.<br>IF UNDER 1 YEAR: Months Days<br>IF UNDER 24 HRS.: Hours Min. |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Caster in a pottery factory.</b><br><b>10b. KIND OF BUSINESS OR INDUSTRY</b>  |  |  |  | <b>11. BIRTHPLACE</b> (State or foreign country) <b>Tennessee</b><br><b>12. CITIZEN OF WHAT COUNTRY</b> <b>USA</b>  |  |   |  |   |  |
| <b>13. FATHER'S NAME</b> <b>Elbert Anders</b>   |  |  |  | <b>14. MOTHER'S MAIDEN NAME</b> <b>Martha E. Jackson</b>  |  |   |  |   |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>Yes</b><br>(If yes give year or dates of service)   |  |  |  | <b>16. SOCIAL SECURITY NO.</b> <b>413-14-3199</b><br><b>17. INFORMANT</b> <b>Mrs. R.A. Anders (wife)</b> Address  |  |   |  |   |  |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b><br>DUE TO (b) <b>420.1</b><br>Conditions, if any, which gave rise to immediate cause (c) <b>420.1</b><br>(e), stating the underlying cause last.<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)   |  |  |  |   |  |   |  | <b>INTERVAL BETWEEN ONSET AND DEATH</b><br><b>Sudden</b>  |  |
| <b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |   |  |   |  |   |  |
| <b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>  |  |  |  | <b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |   |  |
| <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |  | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)   |  | <b>20f. (City or town)</b> (County) (State)   |  |   |  |
| <b>21. I certify</b> that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <b>9/22/61</b> DATE SIGNED<br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/><br>Address (Street, city, town, or county) <b>Glen Burnie, Md.</b> |  |  |  |   |  |   |  |   |  |
| <b>ACTUAL SIGNATURE</b> <i>Gustave H. Faubert</i><br><b>EXAMINER'S NAME</b> (Type) <b>Gustave H. Faubert, M.D.</b>  |  |  |  | <b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b><br><b>22b. DATE THEREOF</b> <b>26 Sept. 61</b><br><b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Bethesda Ch. Cemetery</b><br><b>22d. LOCATION</b> (City, town, or country) (State) <b>Washington Co. Tenn.</b>                |  |   |  |   |  |
| <b>23. FUNERAL DIRECTOR</b> <b>Singleton Funeral Home</b><br>ADDRESS <b>Glen Burnie, Md.</b><br><i>Robert H. Ware</i>   |  |  |  | <b>24a. REC'D BY REGISTRAR</b> <b>SEP 28 '61</b><br><b>24b. REGISTRAR'S SIGNATURE</b> <i>Arthur S. Kraus</i>  |  |   |  |   |  |

575/00



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the funeral director. Pages 1 and 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 3 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

|   |                                |  |   |
|---|--------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>  |                                | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Fort George G. Meade</b>   |                                | c. LENGTH OF STAY IN 1b<br>-   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Kimbrough Army Hospital</b>  |                                | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>-</b> Middle <b>-</b> Last <b>Archer</b>  |                                | 4. DATE OF DEATH<br>Month <b>September</b> Day <b>24</b> Year <b>19 61</b>   |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>Cau</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>23 Sept 61</b>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>-  |                                | 10b. KIND OF BUSINESS OR INDUSTRY<br>-   | 9. AGE (In years last birthday) yrs.<br><b>15</b> Min. <b>20</b>                                  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |                                | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |
| 13. FATHER'S NAME<br><b>David Archer</b>  |                                | 14. MOTHER'S MAIDEN NAME<br><b>Patricia Anne Brown</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br>-   |                                | 16. SOCIAL SECURITY NO.<br>-   |   |
| 17. INFORMANT<br><b>Mother</b>  |                                | Address<br><b>6 Brooks Dr Crownsville, Md.</b>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Prematurity</b><br><b>776X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)<br>DUE TO (c)   |                                |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>15 hrs 20 min</b>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>  |                                | 20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>                  |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                | 20f. (City or town) (County) (State)   |   |
| 21. I certify that (I) ( <del>do not</del> ) attended the deceased from <b>23 Sept 19 61</b> to <b>24 Sept 19 61</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>24 Sept 19 61</b> , and that death occurred at <b>7:30 A.</b> from the causes and on the date stated above. |                                |  |   |
| 22a. SIGNATURE<br><b>Sherman S. Robinson</b>  |                                | 22b. DATE SIGNED<br><b>24 Sept 61</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>SHERMAN S. ROBINSON, Capt., M.C.</b>   |                                | 22d. ADDRESS<br><b>Kimbrough Army Hospital Ft G G Meade, Md.</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                | 23b. DATE THEREOF<br><b>9/26/61</b>  |   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore National</b>   |                                | 23d. LOCATION (City, town, or county) (State)<br><b>Baltimore Md.</b>  |   |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Earl B. Wolcott</b>  |                                | 25a. REC'D BY REGISTRAR<br><b>J. Morris</b>  |   |
| ADDRESS<br><b>6306 Belair Rd</b>  |                                | DATE<br><b>9/26/61</b>   |   |

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Arthur S. H.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.  
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VR A15 (4)  
15M 9/60

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |   |  |  |  |  |  |   |  |  |
|--|--|--|---|--|--|--|--|--|---|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |  |   |  |  |  |  |  |   |  |  |
| CERTIFICATE OF DEATH   |  |  |   |  |  |  |  |  |   |  |  |
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| 09774  |  |  |   |  |  |  |  |  |   |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Anne Arundel</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis</b><br>c. LENGTH OF STAY IN lb<br><b>1 day</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>Anne Arundel General Hospital</b> |  |  |   |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Anne Arundel</b><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>RURAL - Crownsville</b><br>d. STREET ADDRESS<br><b>1</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |   |  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Upton</b><br>First<br><b>H.F.</b><br>Middle<br><b>BAGGER</b><br>Last  |  |  | 4. DATE OF DEATH<br><b>Sept.</b><br>Month<br><b>11</b><br>Day<br><b>1961</b><br>Year                      |  |  | 5. SEX<br><b>Male</b>  |  |  | 6. COLOR OR RACE<br><b>W</b>  |  |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  |  | 8. DATE OF BIRTH<br><b>March 6, 1886</b>  |  |  | 9. AGE (In years last birthday)<br><b>75</b> yrs.  |  |  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>CARPENTER</b>  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>CONSTRUCTION</b>  |  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>MARYLAND</b>   |  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |  |
| 13. FATHER'S NAME<br><b>WILLIAM BAGGER</b>   |  |  |   |  |  | 14. MOTHER'S MAIDEN NAME<br><b>CADELIA LAWRENCE</b>  |  |  |   |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><b>NO</b>  |  |  | 16. SOCIAL SECURITY NO.<br><b>—</b>   |  |  | 17. INFORMANT<br><b>Mrs. C. ROLAND BRADY #2</b><br>Address   |  |  | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Auteriuscenter Heart Disease</b><br>INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b> |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |  |  |  |  |  |   |  |  |
| 20c. TIME OF INJURY<br>Hour e.m. p.m.<br><b>19</b>   |  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  |  | 20f. (City or town) (County) (State)  |  |  |
| 21. I certify that (I) (M.D. or N.P.) attended the deceased from <b>Sept. 10, 1961</b> to <b>Sept. 10, 1961</b> , that (I) (M.D. or N.P.) saw the deceased alive on <b>Sept. 10, 1961</b> , and that death occurred at <b>6:15 A.M.</b> from the causes and on the date stated above.  |  |  |   |  |  |  |  |  |   |  |  |
| 22a. SIGNATURE<br><b>Edward S. Beck</b> M.D.   |  |  |   |  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |  |  | 22b. DATE SIGNED<br><b>9/11/61</b>  |  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Edward S. Beck</b>  |  |  |   |  |  | 22d. ADDRESS<br><b>71 Franklin St., Annapolis, Md.</b>   |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |  |  | 23b. DATE THEREOF<br><b>9-13-61</b>   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ST. STEPHENS CEM.</b>   |  |  | 23d. LOCATION (City, town or county) (State)<br><b>CROWNsville MD.</b>  |  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>JOHN M. TAYLOR</b>  |  |  |   |  |  | ADDRESS<br><b>SOUS ANNAPOLIS MD</b>  |  |  | 25a. REC'D BY REGISTRAR<br><b>SEP 13 '61</b>  |  |  |
|  |  |  |   |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>  |  |  |

(M)

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CONFIDENTIAL

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9786

Reg. Dist. No. 9775

|  |  |   |  |  |  |   |  |  |  |   |  |   |  |  |  |
|--|--|---|--|--|--|---|--|--|--|---|--|---|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND<br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EDGEWATER</u><br>c. LENGTH OF STAY IN 1b<br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CAPE LOCH HAVEN</u>  |  |   |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>A.A.Co.</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EDGEWATER</u><br>d. STREET ADDRESS <u>CAPE LOCH HAVEN</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |  |  |   |  |   |  |  |  |
| <b>3. NAME OF DECEASED</b> (Type or print)<br>First Middle Last<br><u>JACK STANLEY BRADSHAW</u>  |  | <b>4. DATE OF DEATH</b><br>Month Day Year<br><u>9 27 1961</u> |  | <b>5. SEX</b><br><u>M</u>  |  | <b>6. COLOR OR RACE</b><br><u>W</u>   |  | <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | <b>8. DATE OF BIRTH</b><br><u>9-27-1924</u> |  | <b>9. AGE</b> (In years last birthday) <u>37</u> yrs.<br>IF UNDER 1 YEAR Months Days Hours Min. |  | <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>PRINTER</u><br><b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>LINE PRINTER</u><br><b>11. BIRTHPLACE</b> (State or foreign country) <u>KANSAS</u><br><b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u> |  |
| <b>13. FATHER'S NAME</b><br><u>STANLEY BRADSHAW</u>  |  |   |  | <b>14. MOTHER'S MAIDEN NAME</b><br><u>GOLDIE DAVIS</u>   |  |   |  | <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>WW II</u><br><b>16. SOCIAL SECURITY NO.</b><br><b>17. INFORMANT</b> <u>Stanley Bradshaw</u> Address <u>#2</u> |  |   |  |   |  |  |  |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Gun Shot Wound Chest</u><br>DUE TO <u>976X</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO _____<br>(c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____<br>INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> |  |   |  |  |  |   |  |  |  |   |  |   |  |  |  |
| <b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |  |  |   |  |  |  |   |  |   |  |  |  |
| <b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>  |  |   |  | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)<br><u>Self inflicted Gun Shot Wound</u>  |  |   |  |  |  |   |  |   |  |  |  |
| <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour o. m. p. m. <u>9/27 1961</u>   |  |   |  | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>  |  | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Home</u> |  | <b>20f. (City or town)</b> <u>ADCO</u> (County) <u>MD</u> (State)  |  |   |  |   |  |  |  |
| <b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from:</b> Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .   |  |   |  |  |  |   |  |  |  |   |  |   |  |  |  |
| <b>ACTUAL SIGNATURE</b> <u>E. Linhardt</u><br><b>EXAMINER'S NAME (Type)</b> <u>E. Linhardt</u>   |  |   |  | <b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/><br><b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/><br><b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>  |  |   |  | <b>DATE SIGNED</b><br><u>9/27/61</u>   |  |   |  |   |  |  |  |
| <b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>   |  |   |  | <b>22b. DATE THEREOF</b> <u>9-29-61</u>  |  | <b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>ANNAPOLIS NATIONAL</u>                       |  | <b>22d. LOCATION</b> (City, town, or county) <u>ANNAPOLIS</u> (State) <u>MD.</u>   |  |   |  |   |  |  |  |
| <b>23. FUNERAL DIRECTOR'S SIGNATURE</b><br><u>Sam M. Taylor &amp; Sons Annapolis, Md.</u>  |  |   |  |  |  | <b>24a. REC'D BY REGISTRAR</b><br><u>OCT 2 61</u>   |  | <b>24b. REGISTRAR'S SIGNATURE</b><br><u>Arthur S. Anna</u>   |  |   |  |   |  |  |  |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF  
MEDICAL EXAMINERS' CERTIFICATE OF DEATH

|                                      |  |                                      |  |                                      |  |                                      |  |                                       |  |
|--------------------------------------|--|--------------------------------------|--|--------------------------------------|--|--------------------------------------|--|---------------------------------------|--|
| 1. Name of deceased                  |  | 2. Sex                               |  | 3. Age                               |  | 4. Race                              |  | 5. Date of death                      |  |
| 6. Place of death                    |  | 7. Cause of death                    |  | 8. Manner of death                   |  | 9. Signature of medical examiner     |  | 10. Signature of attending physician  |  |
| 11. Signature of medical examiner    |  | 12. Signature of attending physician |  | 13. Signature of medical examiner    |  | 14. Signature of attending physician |  | 15. Signature of medical examiner     |  |
| 16. Signature of attending physician |  | 17. Signature of medical examiner    |  | 18. Signature of attending physician |  | 19. Signature of medical examiner    |  | 20. Signature of attending physician  |  |
| 21. Signature of medical examiner    |  | 22. Signature of attending physician |  | 23. Signature of medical examiner    |  | 24. Signature of attending physician |  | 25. Signature of medical examiner     |  |
| 26. Signature of attending physician |  | 27. Signature of medical examiner    |  | 28. Signature of attending physician |  | 29. Signature of medical examiner    |  | 30. Signature of attending physician  |  |
| 31. Signature of medical examiner    |  | 32. Signature of attending physician |  | 33. Signature of medical examiner    |  | 34. Signature of attending physician |  | 35. Signature of medical examiner     |  |
| 36. Signature of attending physician |  | 37. Signature of medical examiner    |  | 38. Signature of attending physician |  | 39. Signature of medical examiner    |  | 40. Signature of attending physician  |  |
| 41. Signature of medical examiner    |  | 42. Signature of attending physician |  | 43. Signature of medical examiner    |  | 44. Signature of attending physician |  | 45. Signature of medical examiner     |  |
| 46. Signature of attending physician |  | 47. Signature of medical examiner    |  | 48. Signature of attending physician |  | 49. Signature of medical examiner    |  | 50. Signature of attending physician  |  |
| 51. Signature of medical examiner    |  | 52. Signature of attending physician |  | 53. Signature of medical examiner    |  | 54. Signature of attending physician |  | 55. Signature of medical examiner     |  |
| 56. Signature of attending physician |  | 57. Signature of medical examiner    |  | 58. Signature of attending physician |  | 59. Signature of medical examiner    |  | 60. Signature of attending physician  |  |
| 61. Signature of medical examiner    |  | 62. Signature of attending physician |  | 63. Signature of medical examiner    |  | 64. Signature of attending physician |  | 65. Signature of medical examiner     |  |
| 66. Signature of attending physician |  | 67. Signature of medical examiner    |  | 68. Signature of attending physician |  | 69. Signature of medical examiner    |  | 70. Signature of attending physician  |  |
| 71. Signature of medical examiner    |  | 72. Signature of attending physician |  | 73. Signature of medical examiner    |  | 74. Signature of attending physician |  | 75. Signature of medical examiner     |  |
| 76. Signature of attending physician |  | 77. Signature of medical examiner    |  | 78. Signature of attending physician |  | 79. Signature of medical examiner    |  | 80. Signature of attending physician  |  |
| 81. Signature of medical examiner    |  | 82. Signature of attending physician |  | 83. Signature of medical examiner    |  | 84. Signature of attending physician |  | 85. Signature of medical examiner     |  |
| 86. Signature of attending physician |  | 87. Signature of medical examiner    |  | 88. Signature of attending physician |  | 89. Signature of medical examiner    |  | 90. Signature of attending physician  |  |
| 91. Signature of medical examiner    |  | 92. Signature of attending physician |  | 93. Signature of medical examiner    |  | 94. Signature of attending physician |  | 95. Signature of medical examiner     |  |
| 96. Signature of attending physician |  | 97. Signature of medical examiner    |  | 98. Signature of attending physician |  | 99. Signature of medical examiner    |  | 100. Signature of attending physician |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Pages 3 and 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9787

Item 22a, film G294 9/13/61 iwk

CERTIFICATE OF DEATH

09776

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Anne Arundel</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Crownsville</b><br>c. LENGTH OF STAY in 1b<br><b>1 mo. 20 days</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Crownsville State Hospital</b>  |  | 2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Somerset</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Christhill Crisfield</b><br>d. STREET ADDRESS<br><b>151 South 4th Street</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Charles Henry Brown</b>   |  | 4. DATE OF DEATH<br>Month <b>9</b> Day <b>6</b> Year <b>1961</b>   |  |
| 5. SEX<br><b>Male</b><br>6. COLOR OR RACE<br><b>Negro</b>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  |
| 8. DATE OF BIRTH<br><b>9/16/02</b>   |  | 9. AGE (In years last birthday)<br><b>58</b> yrs.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Laborer</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>-----</b>  |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Virginia</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |  |
| 13. FATHER'S NAME<br><b>Samuel Brown</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Henrietta ? Brown</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>No</b>   |  | 16. SOCIAL SECURITY NO.<br><b>083-18-8047</b>  |  |
| 17. INFORMANT<br><b>Unknown</b>  |  | Address<br><b>Hospital Records</b>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Generalized Carcinomatosis</b><br><b>151X</b> DUE TO<br>(b) <b>Carcinoma of the stomach</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO<br>(c) <b>Chronic Brain Syndrome Associated with Arteriosclerosis</b> |  | INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>Chronic Brain Syndrome Associated with Arteriosclerosis</b>   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>-----</b>   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. <b>9</b> p.m. <b>19</b>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>-----</b>   |  | 20f. (City or town) (County) (State)<br><b>-----</b>   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>7/17</b> , 1961 to <b>9/6</b> , 1961, that (I) (we) last saw the deceased alive on <b>9/6</b> , 1961, and that death occurred at <b>8a.m.</b> , from the causes and on the date stated above.   |  |  |  |
| 22a. SIGNATURE<br><b>[Signature]</b>   |  | 22b. DATE SIGNED   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>L. Benedict, M. D.</b>  |  | 22d. ADDRESS<br><b>Crownsville State Hospital, Crownsville, Md.</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE THEREOF<br><b>9/10/61</b>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Somerset county, Md.</b>  |  | 23d. LOCATION (City, town or county) (State)<br><b>Somerset County, Md.</b>  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Anthony E. Ward, 11 1/2 S. 4th St</b>   |  | 25a. REC'D BY REGISTRAR<br><b>SEP 8 '61</b>  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Anthony E. Ward</b>   |  | 25c. REGISTRAR'S SIGNATURE<br><b>Anthony E. Ward</b>   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9788

# CERTIFICATE OF DEATH

Reg. Dist. No. 9788

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>A A Co</u> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Md</u> b. COUNTY <u>A A Co</u>                      |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>  |  | c. LENGTH OF STAY IN 1b  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ANNE ARUNDEL General</u>   |  | d. STREET ADDRESS <u>1</u>   |  |
| 3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>W</u> Last <u>Buckley</u>  |  | 4. DATE OF DEATH Month <u>Sept</u> Day <u>18</u> Year <u>1961</u>  |  |
| 5. SEX <u>Female</u>   | 6. COLOR OR RACE <u>white</u>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>June 5, 1898</u>                               |
| 9. AGE (In years last birthday) <u>63</u> yrs.   |  | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>school teacher</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  |
| 11. BIRTHPLACE (State or foreign country) <u>Galesville Md</u>   |  | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |  |
| 13. FATHER'S NAME <u>William Albert Woodfield</u>  |  | 14. MOTHER'S MAIDEN NAME <u>Ida B. Siegert</u>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)  |  | 16. SOCIAL SECURITY NO. <u>—</u>   |  |
| 17. INFORMANT <u>Miss Josie Nutwell</u> Address <u>Galesville Md</u>   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u><br>443X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive cardiovascular disease</u><br>DUE TO<br>(c) <u>12 hours</u><br>years |  |  | INTERVAL BETWEEN ONSET AND DEATH                                   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <u>19</u>   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                               |
| 21. I certify that I attended the deceased from <u>Sept 18, 1961</u> , to <u>Sept 18, 1961</u> , that I last saw the deceased alive on <u>Sept 18, 1961</u> , and that death occurred at <u>9 P</u> M, from the causes and on the date stated above.   |  |  |  |
| ACTUAL SIGNATURE <u>Willard R. Smith</u> M.D.  |  | ADDRESS (Street, city or town, state) <u>Shady Side, Md</u> DATE SIGNED <u>9/19/61</u>   |  |
| PHYSICIAN'S NAME (Type)  |  |  |  |
| 22a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>   | 22b. DATE THEREOF <u>9/22/61</u>   | 22c. NAME OF CEMETERY OR CREMATORY <u>Quaker</u>   | 22d. LOCATION (City, town, or county) (State) <u>Galesville Md</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>T A Hardisty + Son</u> ADDRESS <u>Galesville Md</u>  |  | 24a. REC'D BY REGISTRAR DATE <u>SEP 27 '61</u>   | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>                  |

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for a burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 9789 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. File No. 9789

|  |   |  |   |
|--|---|--|---|
| 1. PLACE OF DEATH<br>o. COUNTY <u>Anne Arundel</u> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>                        |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>9300 BRILLS - MD.</u>   | c. LENGTH OF STAY IN 1b   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Millersville</u>  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>500. Army Arundel Sen.</u>  |   | d. STREET ADDRESS<br><u>Rt. 2 - Box 87 - Grain Hwy.</u>  |   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <u>Laurena</u> Middle <u>Baser</u> Last <u>Baser</u>   |   | 4. DATE OF DEATH<br>Month <u>9</u> Day <u>5</u> Year <u>1961</u>   |   |
| 5. SEX<br><u>F</u>   | 6. COLOR OR RACE<br><u>W</u>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>9<sup>th</sup> July 1878</u>   |
| 9. AGE (in years last birthday)<br><u>83</u> yrs.  |   | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u>   | IF UNDER 24 HRS.<br>Hours <u>  </u> Min. <u>  </u>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housework (ret.)</u>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>own Home</u>   | 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>                                      |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |   |  |   |
| 13. FATHER'S NAME<br><u>- Gas Augustus Boggs</u>   |   | 14. MOTHER'S MAIDEN NAME<br><u>Melinda Kifer</u>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>No</u>   |   | 16. SOCIAL SECURITY NO.<br><u>None</u>   | 17. INFORMANT<br><u>Mrs. Edith Brown</u> Address <u>Same as #2</u>                                |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac</u><br><u>434.4</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>  </u><br>(c) <u>  </u><br>INTERVAL BETWEEN ONSET AND DEATH <u>  </u>   |   |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>  </u>   |   |  |   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |  |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m. <u>  </u> <u>  </u> <u>19</u>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . |   |  |   |
| ACTUAL SIGNATURE<br><u>E. L. Howard</u>  |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |   |
| EXAMINER'S NAME (Type)<br><u>E. L. Howard</u>  |   | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |   |
|  |   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |   |
| DATE SIGNED<br><u>9/5/61</u>   |   |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   | 22b. DATE THEREOF<br><u>9/8/61</u>  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Odd Fellows Cemetery</u>  | 22d. LOCATION (City, town, or county) (State)<br><u>Flintstone, Md.</u>                           |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>H. Wayne George</u>   |   | 24a. REC'D BY REGISTRAR<br>DATE <u>SEP 8 '61</u>   |   |
| ADDRESS<br><u>Cumberland, Md.</u>  |   | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Howard</u>  |   |

BY MEDICAL EXAMINER'S CERTIFICATE OF DEATH

THE UNIVERSITY OF CHICAGO



## CERTIFICATE OF DEATH

Reg. Dist. No.

09-279

|  |                                    |   |  |
|--|------------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> MARYLAND  |                                    | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>             |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Fort George G. Meade</b>  |                                    | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Fort George G. Meade</b>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Kimbrough Army Hospital</b>   |                                    | d. STREET ADDRESS<br><b>Quarters # 1708-E</b>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>SHIZUE</b> Middle <b>-</b> Last <b>CALAVAN</b>   |                                    | 4. DATE OF DEATH<br>Month <b>September</b> Day <b>5</b> Year <b>19 61</b>   |  |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>Yellow</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>2 Sept 1934</b>                               |
| 9. AGE (In years last birthday)<br><b>27</b> yrs.  |                                    | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months <b>27</b> Days <b>27</b> Hours <b>27</b> Min. <b>27</b>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |                                    | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>-</b>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Japan</b>  |                                    | 12. CITIZEN OF WHAT COUNTRY?<br><b>Japan</b>  |  |
| 13. FATHER'S NAME<br><b>Unknown</b>  |                                    | 14. MOTHER'S MAIDEN NAME<br><b>Hamako Shioya</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>- No</b> (If yes, give war or dates of service) <b>-</b>   |                                    | 16. SOCIAL SECURITY NO. <b>-</b>  |  |
| 17. INFORMANT<br><b>Husband-Leslie R Calavan</b>   |                                    | Address <b>Qtrs # 1708-E Ft Geo G Meade, Md.</b>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Post partum hemorrhage</b><br><b>672x</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Afibrogenemia</b><br>DUE TO (c) <b>-</b> |                                    | INTERVAL BETWEEN ONSET AND DEATH<br><b>5 hrs 15 min</b>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                    | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                    | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>   |                                    | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                    | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>5 Sept</b> , 19 <b>61</b> , to <b>5 Sept</b> , 19 <b>61</b> , that death occurred at <b>11:15 P.</b> , from the causes and on the date stated above.  |                                    |   |  |
| ADDRESS (Street, city or town, state)<br><b>Kimbrough AH Ft Geo G. Meade, Md</b>   |                                    | DATE SIGNED<br><b>5 Sept 61</b>   |  |
| AGUAL SIGNATURE<br><b>George N. Schultz</b>  |                                    | M.D. <b>Kimbrough AH Ft Geo G. Meade, Md</b>  |  |
| PHYSICIAN'S NAME (Type)<br><b>GEORGE N. SCHULTZ, M.D.</b>  |                                    |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 22b. DATE THEREOF<br><b>9/8/61</b> | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Balt. Natl Cem</b>   | 22d. LOCATION (City, town, or county) (State)<br><b>Baltimore Md</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>William Donaldson Laurel Md</b>   |                                    | 24a. REC'D BY REGISTRAR<br>DATE <b>SEP 11 '61</b>   |  |
| 24b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Hines</b>   |                                    |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

750

|  |  |   |  |   |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|---|--|---|--|
| NAME OF DECEASED<br><b>John Doe</b>              |  | AGE<br><b>45</b>                        |  | SEX<br><b>Male</b>                      |  | RACE<br><b>White</b>                    |  | DATE OF BIRTH<br><b>Jan 15 1900</b>     |  | PLACE OF BIRTH<br><b>Baltimore, Md.</b> |  |
| MARRIAGE<br><b>Married</b>                       |  | EDUCATION<br><b>High School</b>         |  | OCCUPATION<br><b>Teacher</b>            |  | RELIGION<br><b>Methodist</b>            |  | MANNER OF DEATH<br><b>Natural</b>       |  | CAUSE OF DEATH<br><b>Heart Disease</b>  |  |
| DATE OF DEATH<br><b>Dec 10 1945</b>              |  | PLACE OF DEATH<br><b>Baltimore, Md.</b> |  | TIME OF DEATH<br><b>10:30 AM</b>        |  | TEMPERATURE<br><b>Normal</b>            |  | PULSE<br><b>Normal</b>                  |  | RESPIRATION<br><b>Normal</b>            |  |
| SIGNATURE OF PHYSICIAN<br><b>Dr. J. H. Smith</b> |  | SIGNATURE OF WITNESS<br><b>John Doe</b> |  | SIGNATURE OF WITNESS<br><b>John Doe</b> |  | SIGNATURE OF WITNESS<br><b>John Doe</b> |  | SIGNATURE OF WITNESS<br><b>John Doe</b> |  | SIGNATURE OF WITNESS<br><b>John Doe</b> |  |
| DATE OF SIGNATURE<br><b>Dec 10 1945</b>          |  | DATE OF SIGNATURE<br><b>Dec 10 1945</b> |  | DATE OF SIGNATURE<br><b>Dec 10 1945</b> |  | DATE OF SIGNATURE<br><b>Dec 10 1945</b> |  | DATE OF SIGNATURE<br><b>Dec 10 1945</b> |  | DATE OF SIGNATURE<br><b>Dec 10 1945</b> |  |

10 JAN 1946

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

09780

|   |                                  |  |  |   |   |   |  |
|---|----------------------------------|--|--|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>  |                                  |  |  | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis</b>  |                                  | c. LENGTH OF STAY in 1b<br><b>10 days</b>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Pasadena</b>   |   | d. STREET ADDRESS<br><b>259 Meadow Road</b>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Anne Arundel General Hospital</b>  |                                  |  |  | a. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |   |  |
| 3. NAME OF DECEASED (Type or print)<br><b>Naomi</b>   |                                  | First <b>D.</b> Middle <b>CARLYLE</b> Last   |  | 4. DATE OF DEATH<br><b>September 24 1961</b>  |   | Month <b>September</b> Day <b>24</b> Year <b>1961</b>   |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>January 7, 1914</b> |   | 9. AGE (In years last birthday)<br><b>47 yrs.</b> | IF UNDER 1 YEAR<br>Months <b></b> Days <b></b>  | IF UNDER 24 HRS.<br>Hours <b></b> Min. <b></b> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Editor</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Western Elec.Co.</b>   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Maryland</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |  |
| 13. FATHER'S NAME<br><b>Edwin R. Carlyle</b>  |                                  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Beulah Poist</b>   |   |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |                                  | 16. SOCIAL SECURITY NO. (If any give war or dates of service)<br><b>215-07-8280</b>  |  | 17. INFORMANT<br><b>Edwin R. Carlyle, Jr; 928 Vanderwood Rd; 28, Md.</b>  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Generalized metastatic carcinomatosis</b><br>DUE TO<br>(b) <b>Cancer of the ovary</b><br>DUE TO<br>(c) <b></b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |                                  |  |  |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>6 months</b><br><b>1 1/2 years.</b>                        |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  |  |  |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |   |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m.<br>p.m.<br><b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (the hospital) attended the deceased from <b>Aug. 1, 1961</b> to <b>Sept. 23, 1961</b> , that (I) (we) saw the deceased alive on <b>Sept. 23, 1961</b> , and that death occurred at <b>7:35 A.M.</b> from the causes and on the date stated above.   |                                  |  |  |   |   |   |  |
| 22a. SIGNATURE<br><b>Arthur Lankford, Jr.</b>   |                                  |  |  | 22b. DATE<br><b>9/25/61</b>   |   | 22c. PHYSICIAN'S NAME (Type)<br><b>Arthur Lankford, Jr.</b>                                       |  |
| 22d. ADDRESS<br><b>2934 Mountain Road, Pasadena, Md.</b>  |                                  |  |  | 22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>            |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 23b. DATE THEREOF<br><b>9-27--1961</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Woodlawn Cemetery</b>  |   | 23d. LOCATION (City, town or county) (State)<br><b>Baltimore Co; Maryland</b>                     |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Edw. S. M. H. H. H.</b>  |                                  |  |  | 25a. REC'D BY REGISTRAR<br><b>SEP 27 '61</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>C. L. H. H. H.</b>   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

08780

8780



I. D.

21-17-2200, 1800, 1900, 2000, 2100, 2200, 2300, 2400, 2500, 2600, 2700, 2800, 2900, 3000, 3100, 3200, 3300, 3400, 3500, 3600, 3700, 3800, 3900, 4000, 4100, 4200, 4300, 4400, 4500, 4600, 4700, 4800, 4900, 5000, 5100, 5200, 5300, 5400, 5500, 5600, 5700, 5800, 5900, 6000, 6100, 6200, 6300, 6400, 6500, 6600, 6700, 6800, 6900, 7000, 7100, 7200, 7300, 7400, 7500, 7600, 7700, 7800, 7900, 8000, 8100, 8200, 8300, 8400, 8500, 8600, 8700, 8800, 8900, 9000, 9100, 9200, 9300, 9400, 9500, 9600, 9700, 9800, 9900, 10000



Ballantine Co. (New York)

Ballantine Co. (New York)

1900-1901

1900-1901

1900-1901

1900-1901

1  
FOR STATE  
HEALTH DEPT.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9792

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09781

TO DEPT. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Anne Arundel</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Glen Burnie</b><br>c. LENGTH OF STAY in 1b<br><b>1 year</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>11 Brooks Terrace</b>  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>a. STATE<br><b>Same</b><br>b. COUNTY<br><b>Same</b><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Same</b><br>d. STREET ADDRESS<br><b>Same</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 3. NAME OF DECEASED<br>(Type in full)<br><b>William Thomas Carter</b>  |  |   |  | 4. DATE OF DEATH<br>Month Day Year<br><b>September 7th 19 61</b>   |  |  |  |
| 5. SEX<br><b>M</b>   |  | 6. COLOR OR RACE<br><b>C</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 8. DATE OF BIRTH<br><b>5/5/81</b>  |  |
| 9. AGE (In years last birthday)<br><b>80 yrs.</b>  |  | IF UNDER 1 YEAR<br>Months Days  |  | IF UNDER 24 HRS.<br>Hours Min.   |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Laborer on the farm</b>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>FARMING</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>St. Mary's County, Md.</b> |  |
| 12. CITIZEN OF WHAT COUNTRY<br><b>USA</b>  |  |   |  |  |  |  |  |
| 13. FATHER'S NAME<br><b>Frank Carter</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>?</b>   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>   |  |   |  | 16. SOCIAL SECURITY NO.<br><b>220-26-4858</b>  |  |  |  |
| 17. INFORMANT<br><b>Thomas James Carter (son)</b>  |  |   |  | Address  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>General Arteriosclerosis</b><br><b>260X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <b>Diabetes</b><br>(c) <b>260X</b> DUE TO<br>(e), stating the underlying cause last.<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)   |  |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>?</b><br><b>?</b>                   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |  |  |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m.<br>p.m.<br><b>19</b>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)                                       |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ACTUAL SIGNATURE <b>Gustave H. Faubert, M.D.</b> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>EXAMINER'S NAME (Type) <b>Gustave H. Faubert, M.D.</b> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/><br>Address (Street, city, town, or county) <b>9/8/61 Glen Burnie, Md.</b> |  |   |  |  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |  | 22b. DATE THEREOF<br><b>9-11-61</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>St Ignatius</b>   |  | 22d. LOCATION (City, town, or country) (State)<br><b>BEL ALTON, MD.</b>    |  |
| 23. FUNERAL DIRECTOR<br><b>The Hunt Funeral Home, Waldorf, MD.</b>   |  |   |  | 24a. REC'D BY REGISTRAR<br><b>SEP 13 '61</b>   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Gustave H. Faubert</b>                    |  |

18781

6382

M

I

John Arundel

John Arundel

11 rooms terrace

William Thomas Carter

2/3/81

September 7th

80

18781

2/3/81

Report to the Board

Frank Carter

1/2/81

1/2/81

1/2/81

1/2/81

1/2/81

1/2/81



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Registrar for burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9793

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. No. 1182

|   |                          |  |                                    |
|---|--------------------------|--|------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY ANNE ARUNDEL MARYLAND  |                          | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)<br>a. STATE MARYLAND b. COUNTY BALTIMORE                           |                                    |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS  |                          | c. LENGTH OF STAY IN 1b 35 Hours Plus  |                                    |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. NAVAL HOSPITAL, ANNAPOLIS, MARYLAND   |                          | d. STREET ADDRESS 1938 VINE STREET   |                                    |
| 3. NAME OF DECEASED (Type or print) First Middle Last JULIA Bellina CLEMONS   |                          | 4. DATE OF DEATH Month Day Year SEPTEMBER 20 19 61   |                                    |
| 5. SEX FEMALE   | 6. COLOR OR RACE NEGROID | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH DECEMBER 25, 1900 |
| 9. AGE (In years last birthday) 61 yrs.   |                          | IF UNDER 1 YEAR Months Days  | IF UNDER 24 HRS. Hours Min.        |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE   |                          | 10b. KIND OF BUSINESS OR INDUSTRY  |                                    |
| 11. BIRTHPLACE (State or foreign country) MARYLAND  |                          | 12. CITIZEN OF WHAT COUNTRY? UNITED STATES   |                                    |
| 13. FATHER'S NAME Thomas BELT   |                          | 14. MOTHER'S MAIDEN NAME Nannie ANDERSON   |                                    |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No   |                          | 16. SOCIAL SECURITY NO. None   |                                    |
| 17. INFORMANT Address Maryland  |                          | Eddie (n) CLEMONS, 1938 Vine Street, Baltimore.  |                                    |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Rupture Liver<br>7 03:00 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                          | INTERVAL BETWEEN ONSET AND DEATH 35 hours  |                                    |
| 20a. EXTERNAL CAUSE WAS PRIMARY or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>  |                          | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell against chair at home on 9/22/61                       |                                    |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 9/22 19 61  |                          | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>  |                                    |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home   |                          | 20f. (City or town) Baltimore (County) (State) Md.   |                                    |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .  |                          |  |                                    |
| ACTUAL SIGNATURE E. Linhardt  |                          | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |                                    |
| EXAMINER'S NAME (Type) E. Linhardt  |                          | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |                                    |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |                          | DATE SIGNED 20 September 1961  |                                    |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Oct. 3, 1961   |                          | 22b. DATE THEREOF  |                                    |
| 22c. NAME OF CEMETERY OR CREMATORY Nat'l.   |                          | 22d. LOCATION (City, town, or county) Baltimore, Md.   |                                    |
| 23. FUNERAL DIRECTOR'S SIGNATURE Address Home 1631 Spruid Hill Ave.   |                          | 24a. REC'D BY REGISTRAR DATE OCT 4 '61   |                                    |
| 24b. REGISTRAR'S SIGNATURE Arthur L. Hume   |                          |  |                                    |



may be released by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

9794

1  
**CERTIFICATE OF DEATH**  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

09783

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Anne Arundel</u> MARYLAND  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>A.A.</u>                  |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>  |  |   |  | c. LENGTH OF STAY IN 1b <u>10</u> <u>Annapolis</u>   |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>174 Pleasant St.</u>   |  |   |  | d. STREET ADDRESS <u>174 Pleasant St.</u>  |  |   |  |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |  |  |   |  |
| 3. NAME OF DECEASED (Type or print) First <u>Benjamin</u> Middle <u>Colbert</u> Last <u>Colbert</u>  |  |   |  | 4. DATE OF DEATH Month <u>9</u> Day <u>12</u> Year <u>1961</u>   |  |   |  |
| 5. SEX <u>Male</u>   |  | 6. COLOR OR RACE <u>Col.</u>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>3-18-1879</u>                                   |  |
| 9. AGE (In years last birthday) <u>82</u> yrs.   |  | IF UNDER 1 YEAR Months <u>8</u> Days <u>2</u> Hours <u>0</u> Min. <u>0</u>  |  | IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>  |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Marlboro, Md.</u>  |  | 11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>  |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>                          |  |
| 13. FATHER'S NAME <u>Frank Colbert</u>   |  |   |  | 14. MOTHER'S MAIDEN NAME <u>Maria Stewart</u>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>   |  | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service)  |  | 17. INFORMANT <u>William Colbert - Annap. Md.</u>  |  | Address   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Hypertensive Cardio-Vascular Disease with</u><br><u>443X</u> DUE TO <u>Renal Damage</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>3 Months</u><br>DUE TO (c) <u>3 Months</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>3 Months</u><br>INTERVAL BETWEEN ONSET AND DEATH <u>3 Months</u> |  |   |  |  |  |   |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <u>19</u>   |  | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)                                |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>July 1</u> , 19 <u>61</u> , to <u>September 12</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>September 12</u> , 19 <u>61</u> , and that death occurred at <u>1:10 A.M.</u> from the causes and on the date stated above.   |  |   |  |  |  |   |  |
| 22a. SIGNATURE <u>R. L. Richardson</u>   |  |   |  | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                     |  | 22b. DATE SIGNED  |  |
| 22c. PHYSICIAN'S NAME (Type) <u>R. L. RICHARDSON</u> MD  |  |   |  | 22d. ADDRESS <u>110 Clay Street, Annapolis, Md.</u>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |  | 23b. DATE THEREOF <u>9-16-61</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>  |  | 23d. LOCATION (City, town, or county) (State) <u>Annapolis, Md.</u> |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>William Beese, D-Annap. Md.</u>  |  |   |  | ADDRESS  |  | 25a. REC'D BY REGISTRAR DATE <u>SEP 20 '61</u>                      |  |
|  |  |   |  | 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kinn</u>   |  |   |  |

MEDICAL CERTIFICATION

100

1978

CERTIFICATE OF DEATH

1978

*[Faint, mostly illegible text, likely bleed-through from the reverse side of the document. Some words like "Name", "Age", "Sex", "Race", "Date of Birth", "Date of Death", "Cause of Death", "Place of Death", "Signature", and "Registrar" are faintly visible.]*

CERTIFICATE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |   |   |  |  |  |  |  |  |                                       |                                   |  |  |
|---|--|--|---|---|--|--|--|--|--|--|---------------------------------------|-----------------------------------|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |  |   |   |  |  |  |  |  |  |                                       |                                   |  |  |
| 9795  |  |  |   |   |  |  |  |  |  |  |                                       |                                   |  |  |
| 09784   |  |  |   |   |  |  |  |  |  |  |                                       |                                   |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>ANNE ARUNDEL</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>ANNAPOLIS</b><br>c. LENGTH OF STAY IN 1b<br><b>MARYLAND</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>HOMWOOD CONVL. HOME</b>   |  |  |   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Montgomery</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Silver Spring</b><br>d. STREET ADDRESS<br><b>Apt. 401 95 East Wayne Ave.</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |  |                                       |                                   |  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>BERTHA MAE CONDON</b>  |  |  |   |   | 4. DATE OF DEATH<br>Month<br><b>September</b><br>Day<br><b>6</b><br>Year<br><b>1961</b>  |  |  |  |  |  |                                       |                                   |  |  |
| 5. SEX<br><b>Female</b>   |  | 6. COLOR OR RACE<br><b>White</b>                     |   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>May 4, 1876</b> |  | 9. AGE (In years last birthday)<br><b>85</b> yrs.                |  |  |                                       |                                   |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>House wife</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>own home</b> |   | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Point Marion, Pa.</b>   |  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>           |  |  |  |                                       |                                   |  |  |
| 13. FATHER'S NAME<br><b>Benj. G. Conn</b>   |  |  |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Mollie Everly</b>   |  |  |  |  |  |                                       |                                   |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>no</b>  |  |  |   |   | 16. SOCIAL SECURITY NO.<br><b>none</b>   |  |  |  |  | 17. INFORMANT<br><b>B. Carl Condon- Son- same as # 2</b><br>Address                                    |                                       |                                   |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><b>490X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.<br>(b) <b>Lobar pneumonia</b><br>DUE TO<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)<br><b>Generalized arteriosclerosis, severe</b> |  |  |   |   |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>12 hrs-</b>   |                                       |                                   |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>      |                                       |                                   |  |  |
| 20c. TIME OF INJURY<br>Hour e.m.<br>p.m.<br><b>19</b>   |  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town)<br><b>ANNAPOLIS, MD.</b>         |  | 20g. (County)<br><b>ANNAPOLIS, MD.</b> |  | 20h. (State)<br><b>ANNAPOLIS, MD.</b> |                                   |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>9/6</b> , 19 <b>61</b> , to <b>9/6</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>9/6</b> , 19 <b>61</b> , and that death occurred at <b>7:55 P.</b> from the causes and on the date stated above.   |  |  |   |   |  |  |  |  |  | 22a. SIGNATURE<br><b>Richard N. Peeler</b><br>22c. PHYSICIAN'S NAME (Type)<br><b>RICHARD N. PEELER</b> |                                       | 22b. DATE SIGNED<br><b>9/6/61</b> |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  |  | 23b. DATE THEREOF<br><b>Sept. 9, 1961</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Evergreen Memorial</b>  |  |  | 23d. LOCATION (City, town or county)<br><b>Point Marion, Pa.</b> |  |  | 23e. (State)<br><b>Pa.</b>            |                                   |  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Hopping Funeral Home</b><br>ADDRESS<br><b>Annapolis, Maryland</b>  |  |  |   |   | 25a. REC'D BY REGISTRAR<br><b>SEP 11 61</b><br>DATE  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Kraus</b> |  |  |  |                                       |                                   |  |  |

(M)

(1)

9795

ANNE ARMY

ANNAPOLIS

HOMEROD CORV. HOME

MAE

XX

Female White

House wife

Benj. G. Goss

None

no

Maryland

Silver Spring

Art. 101 95 East Wayne Ave.

September 6

May 4, 1895

Mollie Eversly

R. Carl Gordon - son - same as 4 2

Point Marion, Pa.

USA

Hopping Tunnel Home Annapolis, Maryland

Sept. 9, 1909

Point Marion, Pa.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9796

## CERTIFICATE OF DEATH

09785

|   |  |  |  |  |   |  |  |
|---|--|--|--|--|---|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <b>Anne Arundel</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Crownsville</b><br>c. LENGTH OF STAY IN 1b<br><b>15 days</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Crownsville State Hospital</b>                 |  |  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Baltimore City</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore</b><br>d. STREET ADDRESS<br><b>524 W. Lanvale Street</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print)<br><b>John Joseph Craig</b>   |  | <b>4. DATE OF DEATH</b><br>Month <b>9</b> Day <b>21</b> Year <b>19 61</b>  |  |  |   |  |  |
| <b>5. SEX</b><br><b>Male</b>  | <b>6. COLOR OR RACE</b><br><b>Negro</b>  | <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br><b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> | <b>8. DATE OF BIRTH</b><br><b>1884</b>                           | <b>9. AGE</b> (In years last birthday) <b>77</b> yrs.<br><b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><b>Bus Driver</b>  | <b>11. BIRTHPLACE</b> (County & State, or foreign country)<br><b>Maryland</b> |  |  |
| <b>12. CITIZEN OF WHAT COUNTRY?</b><br><b>U.S.A.</b>  |  |  |  |  |   |  |  |
| <b>13. FATHER'S NAME</b><br><b>Unknown</b>  |  |  | <b>14. MOTHER'S MAIDEN NAME</b><br><b>Unknown</b>                |  |   |  |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b><br>(Yes, no, or unknown) <b>no</b>   |  | <b>16. SOCIAL SECURITY NO.</b><br><b>Unknown</b>   |  | <b>17. INFORMANT</b><br><b>Hospital Records</b>  |   |  |  |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b><br>DUE TO (b) <b>Pulmonary edema</b><br>DUE TO (c) <b>Broncho pneumonia</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |  | <b>INTERVAL BETWEEN ONSET AND DEATH</b>                                       |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>Chronic Brain Syndrome associated with arteriosclerosis</b>  |  |  |  |  |   |  |  |
| <b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>  |  | <b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)<br>-----  |  |  |   |  |  |
| <b>20c. TIME OF INJURY</b><br>Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)  | <b>20f. (City or town)</b>                                       | <b>(County)</b>  | <b>(State)</b>  |  |  |
| <b>21. I certify that (I) (this hospital) attended the deceased from 9/7, 19 61 to 9/21, 19 61 that (I) (we) last saw the deceased alive on 9/21, 19 61, and that death occurred at 5:30 p.m., from the causes and on the date stated above.</b>  |  |  |  |  |   |  |  |
| <b>22a. SIGNATURE</b><br><b>L. Benedict, M. D.</b>  |  | <b>22b. DATE SIGNED</b><br><b>9/22/61</b>  | <b>22c. PHYSICIAN'S NAME</b> (Type)<br><b>L. Benedict, M. D.</b> |  |   |  |  |
| <b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify)<br><b>BURIAL</b>   |  | <b>23b. DATE THEREOF</b><br><b>9/25/61</b>   | <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><b>MT. AUBURN</b>   | <b>23d. LOCATION</b> (City, town or county)<br><b>BALTIMORE</b>  | <b>(State)</b><br><b>MARYLAND</b>   |  |  |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b><br><b>Charles A. Rice</b>   |  | <b>24b. ADDRESS</b><br><b>661 W. Bane Street</b>   | <b>25a. REC'D BY REGISTRAR</b><br><b>OCT 4 '61</b>               | <b>25b. REGISTRAR'S SIGNATURE</b><br><b>Charles S. Thoms</b>   |   |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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Home Address

Marion

Baltimore City

12 days

Crownville

Baltimore

Crownville State Hospital

221 W. Linnale Street

John

Joseph

Orin

3

21

61

Heard

x

1984

7

Bus Driver

-----

Maryland

U.S.A.

Unknown

Unknown

no

Unknown

Hospital Records

Completed by State Hospital

Interim Report

Summary of Findings

Chronic and Acute Diseases Reported with Recommendations

-----

61

9/21

61

9/27 1:30 p.

61

9/21

9/22/61

x

Crownville State Hospital, Crownville, Md.

I. Benedict, M.D.

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See MB  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Physicians may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9797

## CERTIFICATE OF DEATH

09786

|  |  |  |  |  |  |   |  |  |  |   |  |   |  |
|--|--|--|--|--|--|---|--|--|--|---|--|---|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <b>Anne Arundel</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b><br>c. LENGTH OF STAY IN 1b <b>7 years 4 mos. 14 da.</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Crownsville State Hospital</b>   |  |  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Baltimore City</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b><br>d. STREET ADDRESS <b>Unknown</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |  |  |   |  |   |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print) <b>Elsie Crawford</b>  |  |  |  | <b>4. DATE OF DEATH</b><br>Month <b>9</b> Day <b>22</b> Year <b>1961</b>   |  |   |  |  |  |   |  |   |  |
| <b>5. SEX</b><br><b>Female</b>   |  | <b>6. COLOR OR RACE</b><br><b>Negro</b>  |  | <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | <b>8. DATE OF BIRTH</b><br><b>1/1/06</b>        |  | <b>9. AGE</b> (In years last birthday) <b>55</b> yrs.                        |  | <b>IF UNDER 1 YEAR</b><br>Months <b>5</b> Days <b>14</b> Hours <b>14</b> Min. |  |   |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><b>Domestic</b>  |  |  |  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br>-----  |  |   |  | <b>11. BIRTHPLACE</b> (County & State, or foreign country)<br><b>Unknown</b> |  | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><b>U.S.A.</b>                          |  |   |  |
| <b>13. FATHER'S NAME</b><br><b>Unknown</b>   |  |  |  | <b>14. MOTHER'S MAIDEN NAME</b><br><b>Unknown</b>  |  |   |  |  |  |   |  |   |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b><br>(Yes, no, or unknown) <b>no</b> (If yes give war or dates of service)  |  |  |  | <b>16. SOCIAL SECURITY NO.</b><br><b>Unknown</b>   |  | <b>17. INFORMANT</b><br><b>Hospital Records</b> |  | <b>Address</b>   |  |   |  |   |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c.)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b><br>DUE TO (b) <b>Syphilitic Heart Disease</b><br>DUE TO (c) -----<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. -----<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Old Cerebral Hemorrhage</b> |  |  |  |  |  |   |  |  |  | <b>INTERVAL BETWEEN ONSET AND DEATH</b>                                       |  |   |  |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)<br>-----   |  |   |  |  |  |   |  |   |  |
| <b>20c. TIME OF INJURY</b><br>Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |  | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)  |  | <b>20f. (City or town)</b>                      |  | <b>(County)</b>  |  | <b>(State)</b>  |  |   |  |
| <b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>5/8</b> <b>19</b> <b>54</b> <b>to</b> <b>9/22</b> <b>19</b> <b>61</b> <b>that (I) (we) last saw the deceased alive on</b> <b>9/22</b> <b>19</b> <b>61</b> <b>and that death occurred at</b> <b>8:35 a.m.</b> <b>from the causes and on the date stated above.</b>  |  |  |  |  |  |   |  |  |  |   |  |   |  |
| <b>22a. SIGNATURE</b><br><i>[Signature]</i>  |  |  |  | <b>22b. DATE SIGNED</b><br><b>9/22/61</b>  |  |   |  |  |  |   |  |   |  |
| <b>22c. PHYSICIAN'S NAME</b> (Type)<br><b>L. Benedict, M. D.</b>   |  |  |  | <b>22d. ADDRESS</b><br><b>Crownsville State Hospital, Crownsville, Md.</b>   |  |   |  |  |  |   |  |   |  |
| <b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify)<br><b>Removal</b>   |  |  |  | <b>23b. DATE THEREOF</b><br><b>25 Sept. 1961</b>   |  |   |  | <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><b>University of Md.</b>        |  |   |  | <b>23d. LOCATION</b> (City, town or county) <b>Baltimore</b> (State) <b>Md.</b> |  |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b><br><b>Wm. Reese II</b>   |  |  |  | <b>ADDRESS</b><br><b>108 W. Washington St.</b>   |  |   |  | <b>25a. REC'D BY REGISTRAR</b><br><b>DATE SEP 29 '61</b>                     |  | <b>25b. REGISTRAR'S SIGNATURE</b><br><i>[Signature]</i>                       |  |   |  |

J. Benedict, M. D.      Greenville State Hospital, Greenville, Md.

9/22/01      x

9/22      5/8      6:32      9/22      10

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10      9/22      5/8      6:32      9/22      10

Connors, M. D.      9/22      5/8      6:32      9/22      10

Unknown      Hospital Records      9/22      5/8      6:32      9/22      10

Unknown      9/22      5/8      6:32      9/22      10

Domestic

Unknown

Female      Negro

1/1/00

9/22

Greenville

9

22

01

Greenville State Hospital      Unknown

Greenville      7 years      10 mos. in ga.

Baltimore

10 mos. in ga.

10 mos. in ga.

Baltimore City



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

09787

|   |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>  |  |   |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis</b>  |  |   |  | c. LENGTH OF STAY IN lb<br><b>1 day</b>  |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>Anne Arundel General Hospital</b>  |  |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>RURAL - Mayo</b>  |  |   |  |
|   |  |   |  | d. STREET ADDRESS<br><b>Beverly Beach</b>  |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>William</b> Middle <b>E.</b> Last <b>CRISER</b>   |  |   |  | 4. DATE OF DEATH<br>Month <b>Sept.</b> Day <b>5</b> Year <b>1961</b>   |  |   |  |
| 5. SEX<br><b>Male</b>   |  | 6. COLOR OR RACE<br><b>White</b>            |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 8. DATE OF BIRTH<br><b>Aug. 24, 1878</b>                                    |  |
| 9. AGE (In years last birthday)<br><b>83 yrs.</b>   |  | IF UNDER 1 YEAR<br>Months Days Hours Min.   |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>BROKER</b>  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>West Virginia</b> |  |
| 10b. KIND OF BUSINESS OR INDUSTRY<br><b>REAL ESTATE</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b> |  | 13. FATHER'S NAME<br><b>JACOB CRISER</b>   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>NO</b>  |  |   |  | 16. SOCIAL SECURITY NO.<br><b>---</b>  |  |   |  |
| 17. INFORMANT<br><b>Mrs Clifford P. Grant</b>   |  |   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial failure</b><br>420.0 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Arteriosclerotic heart disease</b><br>DUE TO<br>(c) <b>Benign prostatic hyperplasia</b> |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br><input type="checkbox"/>  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>---</b>   |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. p.m.<br><b>19</b>  |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  |   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>---</b>  |  |   |  | 20f. (City or town) (County) (State)<br><b>---</b>   |  |   |  |
| 21. I certify that (I) (the undersigned) attended the deceased from <b>Aug. 2, 1961</b> to <b>Sept. 5, 1961</b> , that (I) (we) last saw the deceased alive on <b>Sept. 5, 1961</b> , and that death occurred at <b>6:45 PM</b> , from the causes and on the date stated above. |  |   |  |  |  |   |  |
| 22a. SIGNATURE<br><b>Richard I. Hochman</b>   |  |   |  | 22b. DATE SIGNED<br><b>9/6/61</b>  |  |   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Richard I. Hochman</b>   |  |   |  | 22d. ADDRESS<br><b>100 Cathedral St., Annapolis, Md.</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |  |   |  | 23b. DATE THEREOF<br><b>9-9-1961</b>   |  |   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>HILLCREST MEM. CEM.</b>  |  |   |  | 23d. LOCATION (City, town or county) (State)<br><b>ANNAPOLIS MD.</b>   |  |   |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>JOHN M. TAYLOR, SONS</b>   |  |   |  | 25. REC'D BY REGISTRAR<br><b>SEP 8 '61</b>   |  |   |  |
| ADDRESS<br><b>ANNAPOLIS MD</b>  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Kraus</b>   |  |   |  |

VR A15 (4)  
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*[Faint, illegible handwritten text at the bottom of the page]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Physicians may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Titen please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

9799

Item 14 Film G295 9/19/61 iwk

09788

|  |                                  |   |  |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Anne Arundel</u>   |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>e. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>             |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>Annapolis</u>   |                                  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>Crownsville</u>  |  |
| c. LENGTH OF STAY IN 1b<br><u>4 weeks</u>  |                                  | d. STREET ADDRESS<br><u>1 449 Tudor Drive</u>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><u>Anne Arundel General Hospital</u>   |                                  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <u>Emma C.</u> Middle <u>Damico</u> Last <u></u>   |                                  | 4. DATE OF DEATH<br>Month <u>Sept.</u> Day <u>9</u> Year <u>1961</u>  |  |
| 5. SEX<br><u>Female</u>  | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>12th Sept. 1910</u> |
| 9. AGE (In years last birthday)<br><u>50</u> yrs.  |                                  | 10. IF UNDER 1 YEAR<br>Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housework</u>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Own Home</u>  |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><u>Erma, New Jersey</u>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |  |
| 13. FATHER'S NAME<br><u>Elias Snyder</u>   |                                  | 14. MOTHER'S MARDEN NAME<br><u>Ruth Cox</u>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)  |                                  | 16. SOCIAL SECURITY NO.<br><u>None</u>  |  |
| 17. INFORMANT<br><u></u>   |                                  | Address<br><u></u>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Myocardial infarction</u><br><u>420.1</u> DUE TO (b) <u></u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Cardiovascular renal disease with malignant hypertension</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)<br><u></u> |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><u>5 days</u><br><u>1 year</u>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)<br><u></u>  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. <u>19</u> p.m. <u></u>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u></u>  |                                  | 20f. (City or town) (County) (State)<br><u></u>   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>November 1960</u> to <u>9/9</u> , 1961, that (I) <u>(was)</u> last saw the deceased alive on <u>9/9</u> , 1961, and that death occurred at <u>8:30 P.</u> M, from the causes and on the date stated above.  |                                  |   |  |
| 22a. SIGNATURE<br><u>Richard I. Hochman</u>  |                                  | 22b. DATE SIGNED<br><u>9/16/61</u>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>Richard I. Hochman, MD</u>  |                                  | 22d. ADDRESS<br><u>100 Cathedral St., Annapolis, Md.</u>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |                                  | 23b. DATE THEREOF<br><u>13th Sept. 1961</u>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><u>Cedar Hill Cemetery</u>   |                                  | 23d. LOCATION (City, town or county) (State)<br><u>Prince Georges Co., Md.</u>  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><u>A. V. Singleton</u>   |                                  | 25a. REC'D BY REGISTRAR<br><u>SEP 13 '61</u>  |  |
| ADDRESS<br><u>Glen Burnie, Md.</u>   |                                  | 25b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Kline</u>  |  |

VR A15 (4)  
15M 9/60

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(1)



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9800

## CERTIFICATE OF DEATH

09789

|   |  |   |  |   |  |  |   |
|---|--|---|--|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Maryland</b>  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>             |  |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis</b>  |  |   |  | c. LENGTH OF STAY IN 1b<br><b>33 days</b>   |  |  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>Anne Arundel General Hospital</b>  |  |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |   |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Elise</b>  |  | First   |  | Middle  |  | Last   |   |
| 5. SEX<br><b>Female</b>   |  | 6. COLOR OR RACE<br><b>White</b>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>Nov. 15, 1880</b>                               |   |
| 9. AGE (In years last birthday)<br><b>80 yrs.</b>   |  | IF UNDER 1 YEAR<br>Months Days Hours Min.   |  | 4. DATE OF DEATH<br><b>Sept. 1, 1961</b>  |  | 10. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>                            |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housework</b>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Maryland</b> |   |
| 13. FATHER'S NAME<br><b>Henry Lingenfelder</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Emma Parks</b>   |  |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>no</b>  |  |   |  | 16. SOCIAL SECURITY NO.<br><b>none</b>  |  |  |   |
| 17. INFORMANT<br><b>Mr. W. Loren Donaldson, Odenton, Md.</b>  |  |   |  | Address   |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory failure</b><br>332X DUE TO (b) <b>Cerebral thrombosis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b>Generalized arteriosclerosis</b><br>INTERVAL BETWEEN ONSET AND DEATH<br><b>1 day</b><br><b>33 days</b><br><b>5-6 years</b> |  |   |  |   |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |   |  |   |  |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m.<br>p.m.<br><b>19</b>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)                                   |   |
| 21. I certify that (I) <del>(the doctor)</del> attended the deceased from <b>July 30, 1961</b> to <b>Sept. 1, 1961</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>Sept. 1, 1961</b> , and that death occurred at <b>7:55 PM</b> , from the causes and on the date stated above.   |  |   |  |   |  |  |   |
| 22a. SIGNATURE<br><b>Richard L. Hochman</b> M.D.  |  |   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             |  | 22b. DATE SIGNED<br><b>9/2/61</b>                                      |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Dr. Richard I. Hochman</b>   |  |   |  | 22d. ADDRESS<br><b>100 Cathedral St., Annapolis, Md.</b>  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE THEREOF<br><b>4th Sept. '61</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Epiphany Episcopal Ch.Cem. Odenton, Md.</b>  |  | 23d. LOCATION (City, town or county) (State)                           |   |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>L. V. Singleton</b>  |  |   |  | ADDRESS<br><b>Glen Burnie, Md.</b>  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>SEP 6 '61</b>                       |   |
|   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Andrew S. Hanna</b>  |  |  |   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

2000

END

HOLBROOK

1994

Mr. J. L. ...

100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND  
9801  
CERTIFICATE OF DEATH

|  |                              |  |   |
|--|------------------------------|--|---|
| 1. NAME OF DECEASED<br>(Type or Print)<br><b>NANNIE ELIZABETH DORSCH</b>   |                              | 2. DATE OF DEATH<br><b>Sept. 5, 1961</b>   |   |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br><b>Anne Arundel County</b><br>FULL NAME OF HOSPITAL OR INSTITUTION<br><b>301 Creswell Rd</b><br><b>Baltimore 25, Md</b>  |                              | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Md.</b> B. COUNTY <b>Anne Arundel County</b><br>C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><b>Baltimore 25 Anne Arundel County</b><br>D. STREET ADDRESS (If rural, give location)<br><b>301 Creswell Rd, Baltimore 25, Md</b> |   |
| 5. SEX<br><b>F</b>   | 6. COLOR OR RACE<br><b>W</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>W</b>  | 8. DATE OF BIRTH<br><b>Nov. 4, 1878</b> |
| 9. AGE (In years last birthday)<br><b>82</b>   |                              | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.   |   |
| 10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>retired</b>  |                              | 10. B. KIND OF BUSINESS OR INDUSTRY<br><b>Housewife</b>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |                              | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |   |
| 13. FATHER'S NAME<br><b>James Taylor</b>   |                              | 14. MOTHER'S MAIDEN NAME<br><b>Anna Briant</b>   |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>no</b>  |                              | 16. SOCIAL SECURITY NO.  |   |
| 17. INFORMANT<br><b>Berulah Dorsch</b>   |                              | ADDRESS<br><b>Above</b>  |   |
| 18. CAUSE OF DEATH   |                              |  |   |
| I<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Arterio Sclerotic cardio-vascular disease</b><br>DUE TO<br><b>Heart failure</b><br>DUE TO<br><b>Old age</b>  |                              |  |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                              |  |   |
| 19. DATE OF OPERATION  |                              | 19. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |
| 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                              |  |   |
| 22. I certify that (I) (this hospital) attended the deceased from <b>Aug. 7</b> 19 <b>61</b> to <b>Sept 4</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>Sept 4</b> 19 <b>61</b> , and that in (my) (our) opinion death occurred at <b>6:45 a.m.</b> from the causes and on the date stated above. |                              |  |   |
| 23a. SIGNATURE<br><b>Robert DABOLINS</b><br>ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |                              | 23b. ADDRESS<br><b>400 Chain Highway N.W.</b><br><b>Greenbaum, Md.</b>   |   |
| 23c. DATE SIGNED<br><b>Sept 5, 1961</b>  |                              |  |   |
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>B</b>  |                              | 24b. DATE<br><b>9-7-61</b>   |   |
| 24c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cem.</b>   |                              | 24d. LOCATION (City, town, or county) (State)<br><b>Brooklyn, Md.</b>  |   |
| 25a. DATE REC'D BY HEALTH DEPT.<br><b>SEP 7 '61</b>  |                              | 25b. NAME OF REGISTRAR<br><b>Arthur L. Thomas</b>  |   |
| 25c. FUNERAL DIRECTOR<br><b>McCully Funeral Home</b>   |                              | ADDRESS<br><b>1306 Fort</b>  |   |





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9802

## CERTIFICATE OF DEATH

Reg. Dist. No.

08791

|   |  |  |   |
|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Resident before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>           |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis,</b>   |  | c. LENGTH OF STAY IN 1b<br><b>X Edgewater</b>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Homewood Convl. Home</b>   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>SADIE</b> Middle <b>F</b> Last <b>DOVE</b>  |  | 4. DATE OF DEATH<br>Month <b>September</b> Day <b>22</b> Year <b>19 61</b>   |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b>         | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Sept 14, 1884</b>                                |
| 9. AGE (In years last birthday)<br><b>77</b> yrs.   |  | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>House wife</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>own home</b>   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Calvert County, Md.</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |
| 13. FATHER'S NAME<br><b>Henry Robinson</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>Georgeanna (Unknown)</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>no</b>   |  | 16. SOCIAL SECURITY NO.<br><b>none</b>   |   |
| 17. INFORMANT<br><b>Mr George Dove- Son- same as # 2</b>  |  | Address  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>181.0 INANITION</b><br>DUE TO (b) <b>CARCINOMA OF BLADDER</b><br>DUE TO (c) <b>1 YEAR</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <b>AUG</b> 1960, to <b>22 SEPT</b> 1961, that I last saw the deceased alive on <b>22 SEPT</b> 1961, and that death occurred at <b>8:50 A.M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED                              |  |  |   |
| ACTUAL SIGNATURE <b>Edward S. Beck</b> M.D.   |  |  |   |
| PHYSICIAN'S NAME (Type) <b>Edward S. Beck</b>   |  | <b>71 Franklin Street Annapolis, Md.</b>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 22b. DATE THEREOF<br><b>Sept. 26, 61</b> | 22c. NAME OF CEMETERY OR CREMATORY<br><b>All Malloes Cemetery</b>  | 22d. LOCATION (City, town, or county) (State)<br><b>Birdsville, Md.</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Hopping Funeral Home</b>   |  | ADDRESS<br><b>Annapolis, Md.</b>   |   |
| 24a. REC'D BY REGISTRAR<br><b>SEP 27 '61</b>  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>   |   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2802

DATE OF DEATH: June 15, 1981

DECEASED: [Name]

RESIDENT: [Address]

DATE OF BIRTH: [Date]

SEX: [Gender]

EDUCATION: [Level]

OCCUPATION: [Job]

CAUSE OF DEATH: [Cause]

MANNER OF DEATH: [Manner]

REPORTED BY: [Name]

SIGNATURE: [Signature]

DATE: [Date]

PLACE: [Location]

TIME: [Time]

WITNESSES: [Names]

DECEASED'S SIGNATURE: [Signature]

REPORTER'S SIGNATURE: [Signature]

DATE: [Date]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9803

## CERTIFICATE OF DEATH

09792

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>  |  |   |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>   |  |   |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>Annapolis</u>   |  |   |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>Annapolis</u>   |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><u>Anne Arundel General Hospital</u>   |  |   |  | d. STREET ADDRESS<br><u>519 Sixth St.</u>  |  |   |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print)<br><u>Ellen TYLER ELLIOTT</u>  |  |   |  | <b>4. DATE OF DEATH</b><br>Month <u>September</u> Day <u>29</u> Year <u>1961</u>   |  |   |  |
| 5. SEX<br><u>Female</u>  |  | 6. COLOR OR RACE<br><u>White</u>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>June 17, 1911</u>  |  |
| 9. AGE (In years last birthday)<br><u>50 yrs.</u>  |  | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u>  |  | IF UNDER 24 HRS.<br>Hours <u>  </u> Min. <u>  </u>   |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Public Schools A.A.Co. Schools</u> |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><u>Maryland</u>   |  |   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.</u>  |  |   |  |
| 13. FATHER'S NAME<br><u>CLARENCE E. TYLER</u>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>ELLEN BOETTCHER</u>   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>NO</u>   |  |   |  | 16. SOCIAL SECURITY NO.<br><u>—</u>  |  |   |  |
| 17. INFORMANT<br><u>ROBERT H. ELLIOTT JR.</u>  |  |   |  | Address<br><u>#2</u>   |  |   |  |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma of the breast with</u><br><u>154X</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>widespread metastases</u><br>DUE TO (c) <u>  </u> |  |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>10 mcs</u>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   |  |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. <u>  </u> p.m. <u>19</u>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) <u>this hospital</u> attended the deceased from <u>Sept. 28, 1961</u> to <u>Sept. 28, 1961</u> that (I) <u>saw</u> the deceased alive on <u>Sept. 28, 1961</u> , and that death occurred at <u>1:40 A.M.</u> from the causes and on the date stated above.  |  |   |  |  |  |   |  |
| 22a. SIGNATURE<br><u>Richard N. Peeler</u>   |  |   |  | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                     |  | 22b. DATE SIGNED<br><u>1:40 A.M.</u>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>Richard N. Peeler, M.D.</u>   |  |   |  | 22d. ADDRESS<br><u>121 Cathedral St., Annapolis, Md.</u>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>   |  | 23b. DATE THEREOF<br><u>10-1-61</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>HILLCREST</u>   |  | 23d. LOCATION (City, town or county) (State)<br><u>ANNAPOLIS MD</u>   |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><u>John M. Taylor &amp; Sons</u>   |  |   |  | ADDRESS<br><u>Annapolis, Md.</u>   |  | 25a. REC'D BY REGISTRAR<br><u>OCT 2 '61</u>   |  |
|  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles S. Evans</u>  |  |   |  |

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CLARENCE E. TYLER  
1000 1/2 E. 10th St.  
Minneapolis, Minn.

NOV 1941

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

9804

09793

|   |                                  |   |   |   |   |
|---|----------------------------------|---|---|---|---|
| 1. PLACE OF DEATH<br>e. COUNTY <b>ANNE ARUNDEL</b> <b>MARYLAND</b>  |                                  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>  |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>ANNAPOLIS</b>                            |                                  |   | c. LENGTH OF STAY IN 1b<br><b>36 Days</b>   |   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>U.S. NAVAL HOSPITAL, ANNAPOLIS, MARYLAND</b> |                                  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |   |
| 3. NAME OF DECEASED (Type or print)<br><b>Earle Dunlap EVANS Sr.</b>  |                                  |   | 4. DATE OF DEATH<br>Month <b>SEPTEMBER</b> Day <b>6</b> Year <b>19 61</b>   |   |   |
| 5. SEX<br><b>MALE</b>   | 6. COLOR OR RACE<br><b>CAUC.</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>26 JUNE 1889</b>   | 9. AGE (In years last birthday)<br><b>72</b> yrs. | IF UNDER 1 YEAR<br>Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Administrative</b>            |                                  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>U. S. Navy</b>  |   |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>KANSAS</b>  |                                  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>UNITED STATES</b>  |   |   |
| 13. FATHER'S NAME<br><b>Charles Lewis EVANS</b>   |                                  |   | 14. MOTHER'S MAIDEN NAME<br><b>Mary Virginia DUNLAP</b>   |   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>Yes</b>   |                                  |   | 16. SOCIAL SECURITY NO.<br><b>217 266 503</b>   |   |   |
| 17. INFORMANT<br><b>Mrs. Virginia E. MILLER, Baltimore 7, Maryland</b>  |                                  |   | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Emphysema, Pulmonary</b><br>527.1 DUE TO<br>Conditions, if any, which gave rise to immediate cause (b)<br>(e), stating the underlying cause last. DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Asthmatic Bronchitis, Acute</b> |   |   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                               |                                  |   | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   |   |
| 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)                                     |                                  |   | 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour e.m. p.m. 19  |   |   |
| 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>                       |                                  |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   |   |
| 20f. (City or town) (County) (State)  |                                  |   | 21. I certify that (I) (the hospital) attended the deceased from <b>1 August 19 61</b> to <b>6 September 19 61</b> , that (I) (we) last saw the deceased alive on <b>6 September 19 61</b> , and that death occurred at <b>8:07 P.M.</b> from the causes and on the date stated above.  |   |   |
| 22a. SIGNATURE<br><b>[Signature]</b>  |                                  |   | 22b. DATE SIGNED<br><b>7 August 1961</b>  |   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>U. S. Naval Hospital, Annapolis, Maryland</b>  |                                  |   | 22d. ADDRESS<br><b>U. S. Naval Hospital, Annapolis, Maryland</b>  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |                                  |   | 23b. DATE THEREOF<br><b>9-10-61</b>   |   |   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Hillcrest Mem.</b>   |                                  |   | 23d. LOCATION (City, town or county) (State)<br><b>ANNAPOLIS M.D.</b>   |   |   |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>John M. Taylor</b>   |                                  |   | 25a. REC'D BY REGISTRAR<br><b>SEP 8 '61</b>   |   |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Knecht</b>   |                                  |   |   |   |   |

2010

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*Erpophyes palmeri*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
9805  
CERTIFICATE OF DEATH

09794

|   |   |   |  |
|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b><br>c. LENGTH OF STAY IN 1b <b>1 day</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Anne Arundel General Hospital</b>        |   | 2. USUAL RESIDENCE (Where deceased lived, if institutions: Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Anne Arundel</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL - Edgewater</b><br>d. STREET ADDRESS <b>1</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print) <b>David Raymond FARRELL, Jr.</b>   |   | 4. DATE OF DEATH <b>Sept. 14 19 61</b>  |  |
| 5. SEX <b>Male</b>  | 6. COLOR OR RACE <b>White</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH <b>June 15, 1960</b>                                    |
| 9. AGE (In years last birthday) <b>1 yrs.</b>   |   | IF UNDER 1 YEAR<br>Months <b>1</b> Days <b>14</b>   | IF UNDER 24 HRS.<br>Hours <b>19</b> Min. <b>61</b>                       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |   | 10b. KIND OF BUSINESS OR INDUSTRY   | 11. BIRTHPLACE (Country & State, or foreign country) <b>Maryland</b>     |
| 12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>  |   | 13. FATHER'S NAME <b>David Raymond Farrell, Sr.</b>   |  |
| 14. MOTHER'S MAIDEN NAME <b>Mary Virginia Paddy</b>   |   | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |  |
| 16. SOCIAL SECURITY NO. (If yes give war or dates of service)   |   | 17. INFORMANT <b>Hospital records.</b>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Severe dehydration</b><br>571.0 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute gastroenteritis</b><br>DUE TO (c) |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>24 hours</b><br><b>2 days</b>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. <b>19</b><br>p.m.  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)                                     |
| 21. I certify that (I) (the hospital) attended the deceased from <b>9/13</b> , 19 <b>61</b> to <b>9/14</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>9/14</b> , 19 <b>61</b> , and that death occurred at <b>11:30</b> A.M. from the causes and on the date stated above.                            |   |   |  |
| 22a. SIGNATURE <b>Sylvia M. Lim</b> M.D.  |   | 22b. DATE SIGNED <b>9/14/61</b>   |  |
| 22c. PHYSICIAN'S NAME (Type) <b>Sylvia M. Lim</b>   |   | 22d. ADDRESS <b>Mayo Road, Edgewater, Md.</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   | 23b. DATE THEREOF <b>Sept 16, 61</b>  | 23c. NAME OF CEMETERY OR CREMATORY <b>Our Lady of Sorrows</b>   | 23d. LOCATION (City, town or county) (State) <b>Owensville, Maryland</b> |
| 24. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping Funeral Home</b>  |   | 25a. REC'D BY REGISTRAR <b>SEP 18 '61</b>   |  |
| 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hance</b>   |   |   |  |

(M)

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Enlist Sept 16, 61  
Housing, General Home

Our lady of sorrows  
Annapolis, Md.

SEP 10 61  
Annapolis, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
ISM 9/59

9806

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

09795

|   |                               |  |   |
|---|-------------------------------|--|---|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>AA</u> <b>MARYLAND</b>   |                               | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MD</u> b. COUNTY <u>Q. D. Co.</u>            |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SEVERNA PARK</u>  |                               | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SEVERNA PARK</u>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>26 ROBINSON RD.</u>   |                               | d. STREET ADDRESS <u>126 ROBINSON RD.</u>  |   |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                               |  |   |
| <b>3. NAME OF DECEASED</b> (Type or print) First <u>GLADYS</u> Middle <u>VIRGINIA</u> Last <u>FIELDER</u>   |                               | <b>4. DATE OF DEATH</b> Month <u>SEPT.</u> Day <u>21</u> Year <u>1961</u>  |   |
| S. SEX <u>FEMALE</u>  | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>APRIL 5, 1917</u>   |
| 9. AGE (In years lost birthday) <u>44</u> yrs.  |                               | IF UNDER 1 YEAR Months <u>44</u> Days <u>44</u> Hours <u>44</u> Min. <u>44</u>   | IF UNDER 24 HRS. Months <u>44</u> Days <u>44</u> Hours <u>44</u> Min. <u>44</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WELDER</u>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>BETHLEHEM STEEL</u>   |   |
| 11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>   |                               | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |   |
| 13. FATHER'S NAME <u>ELI S. POOLE</u>   |                               | 14. MOTHER'S MAIDEN NAME <u>IRENE ANDERSON</u>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>  |                               | 16. SOCIAL SECURITY NO. <u>224-248942</u>  |   |
| 17. INFORMANT <u>LARENCE D. FIELDER - ABOVE</u>   |                               | Address <u>ABOVE</u>   |   |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinomatosis</u><br><u>171X</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <u>Carcinoma of cervix</u><br>DUE TO (c) <u>3 yrs.</u> |                               | INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs.</u>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NO</u>   |                               | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>   |                               | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                               | 20f. (City or town) (County) (State)   |   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>June</u> 19 <u>60</u> , to <u>21 Sept</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>21 Sept</u> 19 <u>61</u> , and that death occurred at <u>5 P. M.</u> from the causes and on the date stated above.  |                               |  |   |
| 22a. SIGNATURE <u>Glen D. Trettin</u>   |                               | 22b. DATE SIGNED <u>21 Sept 1961</u>   |   |
| 22c. PHYSICIAN'S NAME (Type) <u>GLEN D. TRETIN</u>  |                               | 22d. ADDRESS <u>715 COTTER RD. GLENBURNIE</u>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>   |                               | 23b. DATE THEREOF <u>9-25-61</u>   |   |
| 23c. NAME OF CEMETERY OR CREMATORY <u>MEADOWRIDGE CEM.</u>  |                               | 23d. LOCATION (City, town, or county) (State) <u>DORSEY MD.</u>  |   |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert S. Barranco</u>  |                               | 25a. REC'D BY REGISTRAR <u>SEP 25 '61</u>  |   |
| ADDRESS <u>Severna Park, Md.</u>  |                               | 25b. REGISTRAR'S SIGNATURE <u>C. L. S. Kline</u>   |   |

Blank form with faint horizontal lines and a large rectangular box in the center.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 3 and 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

9807

09796

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u><br>c. LENGTH OF STAY in 1b <u>3 mos.</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Rt. 5 - Box 258A (Magothy Beach)</u>   |  |  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission)<br>e. STATE <u>Maryland</u> <u>Anne Arundel</u><br>b. COUNTY <u>Anne Arundel</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u><br>d. STREET ADDRESS <u>Rt. 5 - Box 258A (Magothy Beach)</u> |  |  |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print)<br>First <u>ADA</u> Middle <u>A.</u> Last <u>FINK</u>  |  |  |  | <b>4. DATE OF DEATH</b><br>Month <u>SEPT</u> Day <u>11</u> Year <u>1961</u>  |  |  |  |
| <b>5. SEX</b><br><u>Female</u>   |  | <b>6. COLOR OR RACE</b><br><u>White</u>  |  | <b>7. MARRIED</b><br><input checked="" type="checkbox"/> NEVER MARRIED<br><input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED  |  | <b>8. DATE OF BIRTH</b><br><u>13th July 1913</u>   |  |
| <b>9. AGE</b> (In years last birthday) <u>48</u> yrs.  |  | <b>IF UNDER 1 YEAR</b><br>Months <u>  </u> Days <u>  </u>  |  | <b>IF UNDER 24 HRS.</b><br>Hours <u>  </u> Min. <u>  </u>  |  | <b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><u>Packer</u> |  |
| <b>11. BIRTHPLACE</b> (County & State, or foreign country)<br><u>Easton, Maryland</u>  |  | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><u>U.S.A.</u>   |  | <b>13. FATHER'S NAME</b><br><u>Charles F. Mallon</u>   |  | <b>14. MOTHER'S MAIDEN NAME</b><br><u>Leona Saxton</u>   |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b><br>(Yes, no, or unknown) <u>no</u>  |  | <b>16. SOCIAL SECURITY NO.</b><br><u>216 03 7170</u>   |  | <b>17. INFORMANT</b><br><u>Mr. Charles Mallon</u>  |  | <b>Address</b><br><u>Same As #2</u>  |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>170X</u> <u>TERMINAL BRONCHO PNEUMONIA</u><br>DUE TO (b) <u>GENERALIZED CARCINOMATOSIS</u><br>DUE TO (c) <u>CARCINOMA UTERUS AND BREAST</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |  |  | <b>INTERVAL BETWEEN ONSET AND DEATH</b><br><u>72 HRS</u><br><u>3 Mo.</u><br><u>8 Mo.</u>                           |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)  |  |  |  |  |  |  |  |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |
| <b>20c. TIME OF INJURY</b><br>Month, Day, Year<br>Hour <u>  </u> e.m. <u>  </u> p.m. <u>  </u>   |  | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)  |  | <b>20f. (City or town)</b> (County) (State)  |  |
| <b>21. I certify that (I) (the hospital) attended the deceased from <u>JULY 20, 1961</u> to <u>SEPT. 11, 1961</u>, that (I) (we) last saw the deceased alive on <u>SEPT 9</u> 1961, and that death occurred at <u>9 PM</u>, from the causes and on the date stated above.</b>  |  |  |  |  |  |  |  |
| <b>22a. SIGNATURE</b><br><u>Arthur Lankford Jr.</u>  |  |  |  | <b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>   |  | <b>22b. DATE SIGNED</b><br><u>9-11-61</u>  |  |
| <b>22c. PHYSICIAN'S NAME (Type)</b><br><u>ARTHUR LANKFORD JR. MD.</u>  |  |  |  | <b>22d. ADDRESS</b><br><u>2934 MOUNTAIN RD. PASADENA MD.</u>   |  |  |  |
| <b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b><br><u>Burial</u>  |  | <b>23b. DATE THEREOF</b><br><u>15th Sept. '61</u>  |  | <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><u>Baltimore Cemetery</u>   |  | <b>23d. LOCATION (City, town or county) (State)</b><br><u>Baltimore, Md.</u>                                       |  |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b><br><u>R. V. Singleton</u>  |  |  |  | <b>25a. REC'D BY REGISTRAR</b><br><u>Glen Burnie, Md.</u>  |  | <b>25b. REGISTRAR'S SIGNATURE</b><br><u>Arthur L. Hanks</u>  |  |



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1961

Post Office Box 2284 (Maggie Beach) Rt. 2 - Box 2284 (Maggie Beach)

Residents 2 Nov. Residents

Post Office Box 2284 (Maggie Beach) Rt. 2 - Box 2284 (Maggie Beach)

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
9808 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. No. 03797

|   |                                   |  |   |
|---|-----------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Anne Arundel</u> MARYLAND   |                                   | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>              |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>   |                                   | c. LENGTH OF STAY IN 1b <u>1 yr. 4 mo.</u>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>USNH, Annapolis, Maryland</u>   |                                   | d. STREET ADDRESS <u>U. S. Naval Academy</u>   |   |
| 3. NAME OF DECEASED (Type or print) First <u>Donald</u> Middle <u>Glynn</u> Last <u>Foley</u>   |                                   | 4. DATE OF DEATH Month <u>September</u> Day <u>28th</u> Year <u>19 61</u>  |   |
| 5. SEX <u>Male</u>  | 6. COLOR OR RACE <u>Caucasian</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>     | 8. DATE OF BIRTH <u>3 November 1941</u> |
| 9. AGE (In years last birthday) <u>19</u> yrs.  |                                   | IF UNDER 1 YEAR Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U. S. Navy</u>   |                                   | 10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>   |   |
| 11. BIRTHPLACE (State or foreign country) <u>Pasadena, Texas</u>  |                                   | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>   |   |
| 13. FATHER'S NAME <u>Thomas G. Foley</u>  |                                   | 14. MOTHER'S MAIDEN NAME <u>Gladys Altha Jefferson</u>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>   |                                   | 16. SOCIAL SECURITY NO. <u>7-5-60 9-28-61</u>  |   |
| 17. INFORMANT (F) <u>Thomas G. Foley</u>  |                                   | Address <u>1132 South Wafer Pasadena, Texas</u>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Dislocation, Cervical Spine, C-3 and 4, with cervical cord compression</u><br>DUE TO <u>9-36-4</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>-----</u><br>DUE TO (c) <u>-----</u>                                    |                                   | INTERVAL BETWEEN ONSET AND DEATH <u>15 Hours</u>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-----</u>  |                                   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                                   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Head on contact with other player while playing football</u> |   |
| 20c. TIME OF INJURY Month, Day, Year <u>4:00 o. m. Sept. 27 1961</u>  |                                   | 20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>  |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>U.S. Naval Academy, Annapolis, Anne Arundel, Md.</u>  |                                   | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . |                                   |  |   |
| ACTUAL SIGNATURE <u>[Signature]</u>   |                                   | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |   |
| EXAMINER'S NAME (Type) <u>E. L. Linhardt</u>  |                                   | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |   |
|   |                                   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>  |                                   | 22b. DATE THEREOF <u>9/29/61</u>   |   |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Corley Funeral Home</u>   |                                   | 22d. LOCATION (City, town, or county) (State) <u>Mexia - Texas</u>   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>   |                                   | 24a. REC'D BY REGISTRAR <u>Oct 2 '61</u>   |   |
| ADDRESS <u>6306 Belair Rd. Baltimore-6, Md</u>  |                                   | 24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>  |   |



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. No. 09798

9809

|  |                               |  |                                      |
|--|-------------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> MARYLAND  |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>                        |                                      |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>  |                               | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>  |                                      |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Homewood Nursing Home</b>  |                               | d. STREET ADDRESS <b>30 Monroe Court</b>   |                                      |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Mollie</b> Middle <b>Jane</b> Last <b>Ford</b>   |                               | 4. DATE OF DEATH<br>Month <b>September</b> Day <b>5</b> Year <b>1961</b>   |                                      |
| 5. SEX <b>Female</b>   | 6. COLOR OR RACE <b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>            | 8. DATE OF BIRTH <b>Oct. 3, 1884</b> |
| 9. AGE (In years last birthday) <b>77</b> yrs.   |                               | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.   |                                      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>  |                                      |
| 11. BIRTHPLACE (State or foreign country) <b>Maryland</b>  |                               | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |                                      |
| 13. FATHER'S NAME <b>Charles A. Miller</b>   |                               | 14. MOTHER'S MAIDEN NAME <b>Anna Lankford</b>  |                                      |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>---</b>   |                               | 16. SOCIAL SECURITY NO. <b>?</b>   |                                      |
| 17. INFORMANT <b>Mr. George W Ford-Son-Riva, Maryland</b>  |                               | Address  |                                      |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARCINOMA OF BREAST, METASTATIC</b><br><b>170 X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)<br>DUE TO (c)<br>INTERVAL BETWEEN ONSET AND DEATH <b>3 YRS.</b> |                               | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>HYPERTENSIVE VASCULAR DISEASE</b> |                                      |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                      |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>   |                               | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |                                      |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                               | 20f. (City or town) (County) (State)   |                                      |
| 21. I certify that I attended the deceased from <b>JAN</b> , 19 <b>56</b> to <b>5 SEPT</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>4 SEPT</b> , 19 <b>61</b> , and that death occurred at <b>4 P</b> .M., from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED <b>9-5-61</b>                         |                               |  |                                      |
| ACTUAL SIGNATURE <b>Edward S. Beck</b> M.D.  |                               |  |                                      |
| PHYSICIAN'S NAME (Type) <b>Edward S. Beck MD</b> <b>73 Franklin Street, Annapolis, Md.</b>   |                               |  |                                      |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |                               | 22b. DATE THEREOF <b>Sept. 7, 61</b>   |                                      |
| 22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Cemetery</b>   |                               | 22d. LOCATION (City, town, or county) (State) <b>Annapolis, Maryland</b>   |                                      |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping Funeral Home</b> ADDRESS <b>Annapolis, Maryland</b>  |                               | 24a. REC'D BY REGISTRAR <b>SEP 8 '61</b> 24b. REGISTRAR'S SIGNATURE <b>C. Thos. S. Hume</b>  |                                      |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2302

05133

Name (Printed) Ann Miller Sex Female Age 30 Years

Address (Printed) 100 North Street, Boston, Mass.

Place of Birth Massachusetts Date of Birth September 2, 1907

Usual Residence 100 North Street, Boston, Mass. Date of Death September 2, 1937

Cause of Death Heart Disease (Printed) Myocardial Infarction

Place of Death Home (Printed) Home

Signature of Physician Dr. George W. ...

Signature of Registrar ...

Signature of Coroner ...

Signature of Medical Examiner ...

Signature of Burial Officer ...

Signature of Undertaker ...

Signature of Funeral Home ...

Signature of Cemetery ...

Signature of Burial Society ...

Signature of Burial Association ...

Signature of Burial Club ...

Signature of Burial League ...

Signature of Burial Order ...

Signature of Burial Society ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

I

MEDICAL CERTIFICATION

2810

Item 7, Film # G297 10/3/61

09799

1. PLACE OF DEATH  
a. COUNTY Anne Arundel MARYLAND  
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis  
c. LENGTH OF STAY IN lb  
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  
a. STATE Maryland b. COUNTY Anne Arundel  
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis  
d. STREET ADDRESS 42 Pleasant St.,  
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) James GANTT  
First Middle Last  
4. DATE OF DEATH Sept. 22 1961  
Month Day Year

5. SEX Male 6. COLOR OR RACE Negro 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH March 16, 1910  
WIDOWED ☒ DIVORCED ☐ 9. AGE (In years last birthday) 51 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Earnest Wesley Gantt 14. MOTHER'S MAIDEN NAME Margaret A. Queen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO. 214-05-0731 17. INFORMANT Margaret Thompson Address 42 Pleasant St.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Acute Pulmonary Edema  
4341 DUE TO (b) Angiostenic Heart Failure  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus (met)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED While ☐ Not While ☐ at work ☐ at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that (I) W. R. Richardson attended the deceased from Sept 22 1961 to Sept 22 1961, that (I) W. R. Richardson saw the deceased alive on Sept 22 1961, and that death occurred at 6:00 A.M. M, from the causes and on the date stated above.

22a. SIGNATURE R. L. Richardson M.D. 22b. DATE SIGNED 9/25/61  
22c. PHYSICIAN'S NAME (Type) R. L. Richardson, M.D. 22d. ADDRESS 110 Clay St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 9-26-1961 23c. NAME OF CEMETERY OR CREMATORY St. Marys 23d. LOCATION (City, town or county) (State) Annapolis Md.

24. FUNERAL DIRECTOR'S SIGNATURE William Reese ADDRESS Annapolis Md. 25a. REC'D BY REGISTRAR SEP 26 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Thoma



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|--|------------------------|--|--|
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><i>John M. Rogers &amp; Sons Annapolis Md.</i> | ADDRESS<br><i>1111</i> | 25a. REC'D BY REGISTRAR<br>DATE <i>ACT 2 '61</i> | 25b. REGISTRAR'S SIGNATURE<br><i>Arthur S. Himes</i> |
|--|------------------------|--|--|

VR A15 (4)  
15M 9/60

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145 Charles Street

1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 26

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W. J. J. J.

התורה והנביא, חלק א, פרק יא, פסוק יא

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(2)

Correlation of the lungs with metastases

124 x 132 32 x 134 x 136 x 138 x 140 x 142 x 144 x 146 x 148 x 150 x 152 x 154 x 156 x 158 x 160 x 162 x 164 x 166 x 168 x 170 x 172 x 174 x 176 x 178 x 180 x 182 x 184 x 186 x 188 x 190 x 192 x 194 x 196 x 198 x 200 x 202 x 204 x 206 x 208 x 210 x 212 x 214 x 216 x 218 x 220 x 222 x 224 x 226 x 228 x 230 x 232 x 234 x 236 x 238 x 240 x 242 x 244 x 246 x 248 x 250 x 252 x 254 x 256 x 258 x 260 x 262 x 264 x 266 x 268 x 270 x 272 x 274 x 276 x 278 x 280 x 282 x 284 x 286 x 288 x 290 x 292 x 294 x 296 x 298 x 300 x 302 x 304 x 306 x 308 x 310 x 312 x 314 x 316 x 318 x 320 x 322 x 324 x 326 x 328 x 330 x 332 x 334 x 336 x 338 x 340 x 342 x 344 x 346 x 348 x 350 x 352 x 354 x 356 x 358 x 360 x 362 x 364 x 366 x 368 x 370 x 372 x 374 x 376 x 378 x 380 x 382 x 384 x 386 x 388 x 390 x 392 x 394 x 396 x 398 x 400 x 402 x 404 x 406 x 408 x 410 x 412 x 414 x 416 x 418 x 420 x 422 x 424 x 426 x 428 x 430 x 432 x 434 x 436 x 438 x 440 x 442 x 444 x 446 x 448 x 450 x 452 x 454 x 456 x 458 x 460 x 462 x 464 x 466 x 468 x 470 x 472 x 474 x 476 x 478 x 480 x 482 x 484 x 486 x 488 x 490 x 492 x 494 x 496 x 498 x 500 x 502 x 504 x 506 x 508 x 510 x 512 x 514 x 516 x 518 x 520 x 522 x 524 x 526 x 528 x 530 x 532 x 534 x 536 x 538 x 540 x 542 x 544 x 546 x 548 x 550 x 552 x 554 x 556 x 558 x 560 x 562 x 564 x 566 x 568 x 570 x 572 x 574 x 576 x 578 x 580 x 582 x 584 x 586 x 588 x 590 x 592 x 594 x 596 x 598 x 600 x 602 x 604 x 606 x 608 x 610 x 612 x 614 x 616 x 618 x 620 x 622 x 624 x 626 x 628 x 630 x 632 x 634 x 636 x 638 x 640 x 642 x 644 x 646 x 648 x 650 x 652 x 654 x 656 x 658 x 660 x 662 x 664 x 666 x 668 x 670 x 672 x 674 x 676 x 678 x 680 x 682 x 684 x 686 x 688 x 690 x 692 x 694 x 696 x 698 x 700 x 702 x 704 x 706 x 708 x 710 x 712 x 714 x 716 x 718 x 720 x 722 x 724 x 726 x 728 x 730 x 732 x 734 x 736 x 738 x 740 x 742 x 744 x 746 x 748 x 750 x 752 x 754 x 756 x 758 x 760 x 762 x 764 x 766 x 768 x 770 x 772 x 774 x 776 x 778 x 780 x 782 x 784 x 786 x 788 x 790 x 792 x 794 x 796 x 798 x 800 x 802 x 804 x 806 x 808 x 810 x 812 x 814 x 816 x 818 x 820 x 822 x 824 x 826 x 828 x 830 x 832 x 834 x 836 x 838 x 840 x 842 x 844 x 846 x 848 x 850 x 852 x 854 x 856 x 858 x 860 x 862 x 864 x 866 x 868 x 870 x 872 x 874 x 876 x 878 x 880 x 882 x 884 x 886 x 888 x 890 x 892 x 894 x 896 x 898 x 900 x 902 x 904 x 906 x 908 x 910 x 912 x 914 x 916 x 918 x 920 x 922 x 924 x 926 x 928 x 930 x 932 x 934 x 936 x 938 x 940 x 942 x 944 x 946 x 948 x 950 x 952 x 954 x 956 x 958 x 960 x 962 x 964 x 966 x 968 x 970 x 972 x 974 x 976 x 978 x 980 x 982 x 984 x 986 x 988 x 990 x 992 x 994 x 996 x 998 x 1000

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 3 and 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
9812  
CERTIFICATE OF DEATH

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if not in residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis</b>   |  |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore</b>                                      |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>Anne Arundel General Hospital</b>   |  |   |  | d. STREET ADDRESS<br><b>40 Rene Avenue</b>  |  |   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>Clarence</b> Middle <b>M.</b> Last <b>George, Sr.</b>   |  |   |  | 4. DATE OF DEATH<br>Month <b>September</b> Day <b>25</b> Year <b>1961</b>   |  |   |  |
| 5. SEX<br><b>Male</b>  |  | 6. COLOR OR RACE<br><b>White</b>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>   |  | 8. DATE OF BIRTH<br><b>February 25, 1906</b>                          |  |
| 10a. MALE OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Checker</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Davidson Transfer</b>   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Foxwell, Va.</b>  |  | 12. CITIZEN OF WHAT COUNTRY?  |  |
| 13. FATHER'S NAME<br><b>Jessie George</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>no</b>   |  |   |  | 16. SOCIAL SECURITY NO.<br><b>212-09-1177</b>   |  |   |  |
| 17. INFORMANT<br><b>Adele Grod George, wife,</b>   |  |   |  | Address <b>2006 E. Madison</b>  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b><br><b>420</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)<br><b>Terminal arteriosclerosis of both feet</b> |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>5 minutes</b><br><b>4 years</b>  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. p.m.<br><b>19</b>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)                                  |  |
| 21. I certify that (I) ( <b>this hospital</b> ) attended the deceased from <b>6/11</b> , 19 <b>61</b> , to <b>9/25</b> , 19 <b>61</b> , that (I) ( <b>no</b> ) last saw the deceased alive on <b>9/25</b> , 19 <b>61</b> , and that death occurred at <b>4:20 P</b> M, from the causes and on the date stated above.   |  |   |  |   |  |   |  |
| 22a. SIGNATURE<br><b>Richard I. Hochman</b>  |  |   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>           |  | 22b. DATE SIGNED  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Dr. Richard I. Hochman</b>  |  |   |  | 22d. ADDRESS<br><b>Cathedral St., Annapolis, Md.</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE THEREOF<br><b>9/29/61</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn Cemetery</b>  |  | 23d. LOCATION (City, town or county) (State)<br><b>Baltimore, Md.</b> |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Schimunek Funeral Home, Inc.</b>  |  |   |  | ADDRESS<br><b>2601-3-5 E. Madison St.</b>   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>SEP 27 '61</b>                     |  |
|  |  |   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Krane</b>                  |  |

(M)

0212

0212

Anna Arnold

Mayland

Annabelle

Paterson

Anna Arnold General Hospital

10 Pine Avenue

Clarence

George St.

September 25

61

White

Male

February 25, 1908

(1)

Dr. Richard J. Hodges

Cathedral St., Annapolis, Md.

Call on me, please, at my home.

224 1st St.

Call on me, please, at my home.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

9813

09802

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Anne Arundel</u> <span style="float: right;">MARYLAND</span><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u><br>c. LENGTH OF STAY IN 1b<br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Anne Arundel General Hospital</u>  |  |  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution, give name before admission)<br>a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Anne Arundel</u></span><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u><br>d. STREET ADDRESS <u>43 Oak Court</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print) <u>Ethel G. GILLMAN</u>   |  | <b>4. DATE OF DEATH</b><br>Month <u>Sept.</u> Day <u>22</u> Year <u>1961</u>   |  | <b>5. SEX</b> <u>Female</u> <b>6. COLOR OR RACE</b> <u>White</u>  |  |  |  |
| <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>Nov. 9, 1883</u><br><b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>  |  | <b>9. AGE</b> (In years last birthday) <u>77</u> yrs.<br>IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>   |  | <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u><br><b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>HOME</u>  |  |  |  |
| <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Maryland</u><br><b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>   |  | <b>13. FATHER'S NAME</b> <u>Engene Goldin</u><br><b>14. MOTHER'S MAIDEN NAME</b> <u>I Garner</u>   |  | <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>  </u><br><b>16. SOCIAL SECURITY NO.</b> (If any) <u>  </u><br><b>17. INFORMANT</b> <u>Mrs. Joseph Sanvartino</u><br><u>16683 Northeast 11 Ct. Miami Fla.</u>   |  |  |  |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u><br><u>332X</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <u>arteriosclerosis, generalized</u><br>(a), stating the underlying cause last. DUE TO (c) <u>  </u> |  |  |  |   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u><br><b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |   |  |  |  |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | <b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>   |  |   |  |  |  |
| <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour a.m. <u>  </u> p.m. <u>  </u>   |  | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u><br><b>20f. (City or town)</b> (County) (State) <u>  </u>  |  |  |  |
| <b>21. I certify</b> that (I) <u>  </u> attended the deceased from <u>Sept. 18</u> , 19 <u>61</u> , to <u>Sept. 21</u> , 19 <u>61</u> , that (I) <u>  </u> saw the deceased alive on <u>Sept. 21</u> , 19 <u>61</u> , and that death occurred at <u>1:10 A.M.</u> from the causes and on the date stated above.   |  |  |  |   |  |  |  |
| <b>22a. SIGNATURE</b> <u>Frank M. Shipley</u> M.D.<br><b>22c. PHYSICIAN'S NAME</b> (Type) <u>Frank M. Shipley, M.D.</u>   |  | <b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/><br><b>22d. ADDRESS</b> <u>121 Cathedral St., Annapolis, Md.</u> |  |   |  |  |  |
| <b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u><br><b>23b. DATE THEREOF</b> <u>Sept 25-61</u>  |  | <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Cedar Bluffs</u><br><b>23d. LOCATION</b> (City, town or county) (State) <u>Annapolis Md</u>   |  | <b>25a. REC'D BY REGISTRAR</b> <u>SEP 25 61</u><br><b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Frank</u>   |  |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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George W. F. ...  
Singapore ...

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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9814  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
09803

|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>A. A.</u> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>A. A.</u>                 |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>   |  | c. LENGTH OF STAY IN 1b <u>10</u>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2003-B West Street</u>  |  | d. STREET ADDRESS <u>2003-B West St. 1</u>   |  |
| 3. NAME OF DECEASED (Type or print) <u>Edmond Shipley Givan</u>   |  | 4. DATE OF DEATH<br>Month <u>9</u> Day <u>15</u> Year <u>1961</u>  |  |
| 5. SEX <u>Male</u>  | 6. COLOR OR RACE <u>Col</u>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>3-20-1918</u>                                  |
| 9. AGE (In years last birthday) <u>43</u> yrs.  |  | 10. IF UNDER 1 YEAR Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Welder</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Mosconi</u>   |  |
| 11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>   |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  |
| 13. FATHER'S NAME <u>Sam Givan</u>  |  | 14. MOTHER'S MAIDEN NAME <u>Ethel Givan</u>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)  |  | 16. SOCIAL SECURITY NO. <u>446-209333</u>  |  |
| 17. INFORMANT <u>Louise G. Givan</u>  |  | Address <u>2003-B West St.</u>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma with metastases to vital structures</u><br>199X DUE TO (b) <u>to vital structures</u><br>Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause lost. (c) _____<br>DUE TO (c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____<br>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <u>19</u>  | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                               |
| 21. I certify that (I) (this hospital) attended the deceased from <u>4-10-61</u> 19 <u>61</u> , to <u>9-15-61</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>9-15-61</u> , and that death occurred at <u>4:45</u> AM, from the causes and on the date stated above.   |  |  |  |
| 22a. SIGNATURE <u>A. T. Allen</u>   |  | 22b. DATE SIGNED   |  |
| 22c. PHYSICIAN'S NAME (Type) <u>A. T. ALLEN</u>   |  | 22d. ADDRESS <u>62 CATHERAL ST</u>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   | 23b. DATE THEREOF <u>9-17-61</u>   | 23c. NAME OF CEMETERY OR CREMATORY <u>Cherry Chapel</u>  | 23d. LOCATION (City, town, or county) (State) <u>Owensville Md</u> |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese</u>   |  | 25a. REC'D BY REGISTRAR <u>Anna M. D.</u>  |  |
| 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>   |  | DATE <u>SEP 21 '61</u>   |  |

CERTIFICATE OF GRADE

1914

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1914



# 1 FOR STATE HEALTH DEPT.

TO DEF. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

## MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9815

### MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09804

|   |   |  |   |
|---|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>c. LENGTH OF STAY IN 1b<br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Anne Arundel</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>d. STREET ADDRESS<br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>ANDREW B. GRANT</b>  |   | 4. DATE OF DEATH<br>Month <b>September</b> Day <b>17</b> Year <b>1961</b>  |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>Colored</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><b>11-11-1900</b>                                   |
| 9. AGE (In years last birthday)<br><b>60</b> yrs.   |   | 10. IF UNDER 1 YEAR<br>Months <b>60</b> Days <b>0</b> Hours <b>0</b> Min.  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Maryland</b>   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>Maryland</b>  |   |
| 13. FATHER'S NAME<br><b>Charles W. Grant</b>  |   | 14. MOTHER'S MAIDEN NAME<br><b>Elizabeth P. Dickson</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)<br><b>No</b>   |   | 16. SOCIAL SECURITY NO.<br><b>770</b>  |   |
| 17. INFORMANT<br><b>Charles S. Petty</b>  |   | Address<br><b>Box 152, Annapolis Blvd.</b>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Decomposed Body.</b><br>795.0 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO<br>(c)  |   |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   |  |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |   | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. p.m.<br><b>19</b>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                                    |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> |   |  |   |
| ACTUAL SIGNATURE<br><b>Charles S. Petty</b>   |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |   |
| EXAMINER'S NAME (Type)<br><b>Charles S. Petty, M.D.</b>   |   | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>   |   |
|   |   | DEPUTY MEDICAL EXAMINER <input type="checkbox"/>   |   |
|   |   | DATE SIGNED<br><b>9/18/61</b>  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)   | 22b. DATE THEREOF<br><b>9-20-61</b>   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Brewer Hill</b>   | 22d. LOCATION (City, town, or country) (State)<br><b>Annapolis, Md.</b> |
| 23. FUNERAL DIRECTOR<br><b>William Reese, Jr. Annap. Md.</b>  |   | 24a. REC'D BY REGISTRAR<br><b>SEP 19 1961</b>  |   |
|   |   | 24b. REGISTRAR'S SIGNATURE<br><b>William L. Grant</b>  |   |

MEDICAL CERTIFICATION

00804

2122

(M)

recovered body

X \_\_\_\_\_

X \_\_\_\_\_

9815

CERTIFICATE OF DEATH

Reg. 09805

|   |  |   |  |  |  |   |   |
|---|--|---|--|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>          |  |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis</b>  |  |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis</b>   |  |   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Anne Arundel General</b>   |  |   |  | d. STREET ADDRESS<br><b>1116 Smith Ave.</b>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>JULIA</b> Middle <b>GREENFIELD</b> Last   |  |   |  | 4. DATE OF DEATH<br>Month <b>SEPTEMBER</b> Day <b>30</b> , Year <b>19 61</b>   |  |   |   |
| 5. SEX<br><b>Female</b>   |  | 6. COLOR OR RACE<br><b>White</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>1884</b>   |   |
| 9. AGE (In years last birthday)<br><b>77</b> yrs.   |  | IF UNDER 1 YEAR<br>Months Days Hours Min.   |  | IF UNDER 24 HRS.   |  |   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>House wife</b>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>own home</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Poland</b>  |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |   |  |  |  |   |   |
| 13. FATHER'S NAME<br><b>Herman Brown</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Mollie (Unknown)</b>  |  |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>no no</b>   |  |   |  | 16. SOCIAL SECURITY NO.<br><b>Husbands # 220 16 5040</b>   |  | 17. INFORMANT Address<br><b>Mr. Sam A. Greenfield- Husband - same as # 2</b>                      |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CEREBRAL THROMBOSIS</b><br><b>332X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ARTERIOSCLEROTIC HEART DISEASE</b> |  |   |  |  |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>28 Hours</b> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I attended the deceased from <b>29 SEPT, 1961</b> to <b>30 SEPT, 1961</b> , that I last saw the deceased alive on <b>30 SEPT, 1961</b> , and that death occurred at <b>1030 P.M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED<br><b>September 30, 1961</b>   |  |   |  |  |  |   |   |
| ACTUAL SIGNATURE <b>Edward S. Beck</b> M.D.   |  |   |  |  |  |   |   |
| PHYSICIAN'S NAME (Type) <b>Edward S. Beck MD.</b>   |  |   |  | Franklin Street, Annapolis, Maryland   |  |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 22b. DATE THEREOF<br><b>Oct. 1, 1961</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Kneseth Israel Cemeter.</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Annapolis, Md.</b>                            |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Hopping Funeral Home</b>   |  |   |  | ADDRESS<br><b>Annapolis, Md.</b>   |  | 24a. REC'D BY REGISTRAR<br>DATE <b>OCT 3 '61</b>  |   |
|   |  |   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>   |  |   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

|                   |  |               |  |      |  |       |  |           |  |            |  |                |  |                |  |                |  |                |  |                |  |               |  |                        |  |                        |  |                        |  |                        |  |
|-------------------|--|---------------|--|------|--|-------|--|-----------|--|------------|--|----------------|--|----------------|--|----------------|--|----------------|--|----------------|--|---------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|
| Name of Deceased  |  | Date of Birth |  | Sex  |  | Race  |  | Color     |  | Religion   |  | Marital Status |  | Occupation     |  | Cause of Death |  | Place of Death |  | Date of Death  |  | Time of Death |  | Signature of Physician |  | Signature of Registrar |  | Signature of Informant |  |                        |  |
| John Smith        |  | 1910          |  | Male |  | White |  | Caucasian |  | Protestant |  | Single         |  | Farmer         |  | Heart Disease  |  | Home           |  | 1961           |  | 10:00 AM      |  | J. H. Smith            |  | J. H. Smith            |  | J. H. Smith            |  |                        |  |
| Name of Informant |  | Relationship  |  | Age  |  | Sex   |  | Race      |  | Color      |  | Religion       |  | Marital Status |  | Occupation     |  | Cause of Death |  | Place of Death |  | Date of Death |  | Time of Death          |  | Signature of Informant |  | Signature of Registrar |  | Signature of Informant |  |
| John Smith        |  | Son           |  | 25   |  | Male  |  | White     |  | Caucasian  |  | Protestant     |  | Single         |  | Farmer         |  | Heart Disease  |  | Home           |  | 1961          |  | 10:00 AM               |  | J. H. Smith            |  | J. H. Smith            |  | J. H. Smith            |  |
| Name of Informant |  | Relationship  |  | Age  |  | Sex   |  | Race      |  | Color      |  | Religion       |  | Marital Status |  | Occupation     |  | Cause of Death |  | Place of Death |  | Date of Death |  | Time of Death          |  | Signature of Informant |  | Signature of Registrar |  | Signature of Informant |  |
| John Smith        |  | Son           |  | 25   |  | Male  |  | White     |  | Caucasian  |  | Protestant     |  | Single         |  | Farmer         |  | Heart Disease  |  | Home           |  | 1961          |  | 10:00 AM               |  | J. H. Smith            |  | J. H. Smith            |  | J. H. Smith            |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If 24 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |   |  |   |  |  |  |  |  |   |  |
|---|--|---|--|---|--|--|--|--|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |   |  |   |  |  |  |  |  |   |  |
| CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |  |  |   |  |
| 9817  |  |   |  |   |  |  |  |  |  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>A.A. Co.</u> <u>MARYLAND</u>  |  |   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Mo.</u> b. COUNTY <u>A.A. Co.</u> |  |  |  |   |  |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>ANNAPOLIS</u>  |  |   |  |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>ANNAPOLIS</u>                                   |  |  |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><u>500 State St.</u>  |  |   |  |   |  | e. STREET ADDRESS<br><u>500 State St.</u>  |  |  |  |   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <u>Elizabeth</u> Middle <u>W.</u> Last <u>HARMON</u>  |  |   |  |   |  | 4. DATE OF DEATH<br>Month <u>9</u> Day <u>26</u> Year <u>1961</u>  |  |  |  |   |  |
| 5. SEX<br><u>F</u>  |  | 6. COLOR OR RACE<br><u>W</u>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>2-20-1876</u>   |  | 9. AGE (In years last birthday) <u>85</u> yrs.   |  | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u> |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>HOME</u>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>HOME</u>  |  |  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><u>MARYLAND</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>                                     |  |
| 13. FATHER'S NAME<br><u>FRED W<sup>M</sup> HEINBUCH</u>   |  |   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>ELISA BECK</u>  |  |  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>  </u>  |  |   |  |   |  | 16. SOCIAL SECURITY NO.<br><u>  </u>   |  |  |  |   |  |
| 17. INFORMANT<br><u>Mrs Rudolph M. J. Smith</u>   |  |   |  |   |  | Address <u>(2)</u>   |  |  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u><br>332X DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <u>CEREBRAL ARTERIOSCLEROSIS</u><br>(e), stating the underlying cause last. DUE TO (c) <u>  </u> |  |   |  |   |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>1 Hour.</u><br><u>6 YRS</u>                |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>  </u>  |  |   |  |   |  |  |  |  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |   |  |
| 20c. TIME OF INJURY<br>Hour a.m. <u>  </u> p.m. <u>19</u>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town)  |  | 20g. (County)  |  | 20h. (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 1955 to <u>26 SEPT. 1961</u> , that (I) (we) last saw the deceased alive on <u>25 SEPT. 1961</u> , and that death occurred at <u>8 A.M.</u> , from the causes and on the date stated above.   |  |   |  |   |  |  |  |  |  |   |  |
| 22a. SIGNATURE<br><u>Edward S. Beck</u>   |  |   |  |   |  | M.D.   |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22b. DATE SIGNED  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>Dr. Edward S. Beck</u>   |  |   |  |   |  | 22d. ADDRESS<br><u>71 Franklin St., Annapolis, Md.</u>   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |  | 23b. DATE THEREOF<br><u>Sept 28-1961</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Lodan Bluff Cemt</u>   |  | 23d. LOCATION (City, town or county)<br><u>Annapolis</u>   |  | 23e. (State)<br><u>Md</u>  |  | 23f. (Country)  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><u>John M. Taylor Sons Annapolis Md.</u>  |  |   |  |   |  | ADDRESS<br><u>  </u>   |  | 25a. REC'D BY REGISTRAR<br><u>DACT 2 '61</u>   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Arthur L. Evans</u>                              |  |

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FOR STATE  
HEALTH DEPT.  
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09807

|   |  |  |   |
|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Anne Arundel</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Glen Burnie</b><br>c. LENGTH OF STAY IN 1b<br><b>Few seconds</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>Route # 3-B 1 1/2 mile South of Glen Burnie.</b>   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Anne Arundel</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Glen Burnie</b><br>d. STREET ADDRESS<br><b>914 Phyllen Court, Glen Burnie.</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>James Charles Hickey</b>   |  | 4. DATE OF DEATH<br>Month Day Year<br><b>September 2nd. 19 61</b>  |   |
| 5. SEX<br><b>M</b>  | 6. COLOR OR RACE<br><b>W</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><b>12/3/39</b>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Medical Technicologist (Federal)</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY  | 9. AGE (In years last birthday)<br><b>21</b> yrs.   |
| 11. BIRTHPLACE (State or foreign country)<br><b>San Antonio, Texas</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |
| 13. FATHER'S NAME<br><b>Frank L. Hickey</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Argerru Belk</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |  | 16. SOCIAL SECURITY NO.<br><b>215-40-3509</b>  |   |
| 17. INFORMANT<br><b>Mr. Frank L. Hickey (father)</b>  |  | Address  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Fracture of skull, crushed chest.</b><br>DUE TO (b)<br>DUE TO (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>Sudden</b> |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.   |  | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>Hit two cars, one heading North and the other heading South.</b>   |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br><b>12.05 A.M. 9/2/61</b>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>Route 3-B</b>   | 20f. (City or town) (County) (State)<br><b>Glen Burnie, A.A. Md.</b>                              |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  |  |  |   |
| ACTUAL SIGNATURE<br><b>Gustave H. Faubert</b>   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |   |
| EXAMINER'S NAME (Type)<br><b>Gustave H. Faubert, M.D.</b>   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> 9/2/61 DATE SIGNED   |   |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |  | Address (Street, city, town, or county)<br><b>Glen Burnie, Md.</b>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 22b. DATE THEREOF<br><b>9/5/61</b>   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Mem</b>  | 22d. LOCATION (City, town, or country) (State)<br><b>Glen Burnie, Md</b>                          |
| 23. FUNERAL DIRECTOR<br><b>Hopping &amp; KIRKLEY, Glen Burnie</b>   |  | 24a. REC'D BY REGISTRAR<br><b>SEP 5 '61</b>  |   |
|   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Knaut</b>   |   |

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15.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
1SM 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

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|---|--|----------------------------------|--|--|--|--|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> MARYLAND   |  |                                  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>  |  |  |  |  |  |   |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Brooklyn Park</b>  |  |                                  |  | c. LENGTH OF STAY IN 1b<br><b>5 yrs.</b>   |  |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Brooklyn Park</b>   |  |   |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>4 Fifth Ave.</b>   |  |                                  |  | d. STREET ADDRESS<br><b>4 Fifth Ave.</b>   |  |  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br><b>Doris Magdalene Howard</b>  |  |                                  |  | 4. DATE OF DEATH<br>Month <b>Sept.</b> Day <b>25</b> Year <b>1961</b>  |  |  |  |  |  |   |  |   |  |
| 5. SEX<br><b>Female</b>   |  | 6. COLOR OR RACE<br><b>White</b> |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                    |  | 8. DATE OF BIRTH<br><b>Nov. 12, 1927</b> |  | 9. AGE (In years lost birthday)<br><b>33</b> yrs.  |  | IF UNDER 1 YEAR<br>Months Days Hours Min. |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |  |                                  |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  |  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |  |   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S.</b>                                  |  |
| 13. FATHER'S NAME<br><b>John Neenan</b>   |  |                                  |  | 14. MOTHER'S MAIDEN NAME<br><b>Mary Hughes</b>   |  |  |  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |  |   |  | 16. SOCIAL SECURITY NO.<br><b>215-22-9326</b>                                 |  |
| 17. INFORMANT<br><b>Mr. James N. Howard</b>   |  |                                  |  | Address<br><b>Same</b>   |  |  |  | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of Ovary &amp; Metastasis</b><br>DUE TO <b>175.0</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) DUE TO<br>(c) DUE TO |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>4 wks.</b>                             |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |                                  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  |  |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                                  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |  |  |   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. 19   |  |                                  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  |  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  |   |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>5-28</b> 19 <b>60</b> , to <b>9-25</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>9-25</b> 19 <b>61</b> , and that death occurred at <b>1 P.M.</b> from the causes and on the date stated above. |  |                                  |  |  |  |  |  |  |  |   |  |   |  |
| 22a. SIGNATURE<br><b>Aaron C. Selled</b>  |  |                                  |  | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/><br>22d. ADDRESS<br><b>707 E. Fort Ave. Baltimore, Md.</b> |  |  |  | 22b. DATE SIGNED<br><b>Sept. 27, 1961</b>  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  |                                  |  | 23b. DATE THEREOF<br><b>Sept. 28, 1961</b>   |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Mem. Pk.</b>   |  |   |  | 23d. LOCATION (City, town, or county) (State)<br><b>Glen Burnie, Maryland</b> |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>George J. Gonce</b>  |  |                                  |  | ADDRESS<br><b>4001 Ritchie Hwy. (25)</b>   |  |  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>OCT 2 '61</b>   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>                          |  |

George J. Gonce

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9820

## CERTIFICATE OF DEATH

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|  |  |   |  |  |  |  |  |  |  |   |  |   |  |  |  |
|--|--|---|--|--|--|--|--|--|--|---|--|---|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u><br>c. LENGTH OF STAY IN 1b <u>6 months</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Plaza Manor Nursing Home</u>  |  |   |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission)<br>STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Saverna Park, Earleigh Hts.</u><br>d. STREET ADDRESS <u>Rt. 2 Box 383</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |  |   |  |   |  |  |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print) <u>Carrie</u> <u>Jeffries</u><br>First Middle Last   |  |   |  | <b>4. DATE OF DEATH</b><br><u>September 3</u> <u>19 61</u><br>Month Day Year   |  |  |  |  |  |   |  |   |  |  |  |
| <b>5. SEX</b><br><u>Female</u>   |  | <b>6. COLOR OR RACE</b><br><u>Negro</u> |  | <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>  |  | <b>8. DATE OF BIRTH</b><br><u>July 14, 1878</u>  |  | <b>9. AGE</b> (In years last birthday) <u>83</u> yrs.                                |  | <b>IF UNDER 1 YEAR</b><br>Months Days   |  | <b>IF UNDER 24 HRS.</b><br>Hours Min.                       |  |  |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Matron-Penn.R.R. Station Railroad</u>  |  |   |  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><u>Railroad</u>  |  |  |  | <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Richmond, Virginia</u> |  |   |  | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><u>U.S.A.</u>        |  |  |  |
| <b>13. FATHER'S NAME</b><br><u>William Jeffries</u>  |  |   |  | <b>14. MOTHER'S MAIDEN NAME</b><br><u>Martha Brown</u>   |  |  |  |  |  |   |  |   |  |  |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)  |  |   |  | <b>16. SOCIAL SECURITY NO.</b><br><u>114-12-1784</u>   |  |  |  | <b>17. INFORMANT</b> <u>Mrs. Alice Brown-A.A.Co.D.P.W.</u> Address                   |  |   |  |   |  |  |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u><br><u>422.1</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |  |   |  |  |  |  |  |  |  |   |  | <b>INTERVAL BETWEEN ONSET AND DEATH</b><br><u>Many yrs.</u> |  |  |  |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  |  |  |  |  |  |  |   |  |   |  | <b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.) |  |
| <b>20c. TIME OF INJURY</b><br>Hour a.m. <u>19</u> p.m.   |  |   |  | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)  |  | <b>20f. (City or town)</b> (County) (State)  |  |   |  |   |  |  |  |
| <b>21. I certify</b> that (I) <u>(this hospital)</u> attended the deceased from <u>March 15, 1961</u> , to <u>Sept. 3, 1961</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>August 19, 1961</u> , and that death occurred at <u>5:30 P.M.</u> from the causes and on the date stated above.   |  |   |  |  |  |  |  |  |  |   |  |   |  |  |  |
| <b>22a. SIGNATURE</b><br><u>James M. Pair</u> M.D.   |  |   |  |  |  | <b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> |  | <b>22b. DATE SIGNED</b><br><u>Sept. 4, 1961</u>                                      |  |   |  |   |  |  |  |
| <b>22c. PHYSICIAN'S NAME</b> (Type)<br><u>James M. Pair, M.D.</u>  |  |   |  |  |  | <b>22d. ADDRESS</b><br><u>400 N. Carrollton Avenue Balto. 23, Md.</u>  |  |  |  |   |  |   |  |  |  |
| <b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify)<br><u>Burial</u>  |  |   |  | <b>23b. DATE THEREOF</b><br><u>9-6-61</u>  |  | <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><u>Silos Church</u>   |  |  |  | <b>23d. LOCATION</b> (City, town or county) (State)<br><u>Earleigh Hts. Md.</u> |  |   |  |  |  |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b><br><u>C.E. Hicks 111</u>   |  |   |  |  |  | <b>ADDRESS</b><br><u>Annapolis, Maryland</u>   |  | <b>25a. REC'D BY REGISTRAR</b><br><u>SEP 11 '61</u>                                  |  | <b>25b. REGISTRAR'S SIGNATURE</b><br><u>Arthur S. Kraus</u>                     |  |   |  |  |  |

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C. L. Nichols III, Maryland

Salmon Churn

Washington, D.C.

100 W. Jefferson Avenue, Suite 2310

August 1, 1961

July 12, 1961

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If the deceased is not buried or cremated within 24 hours after death, the death certificate must be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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MEDICAL CERTIFICATION

| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |                                   |  |  |   |  |  |                                      |  |  |
|--|--|-----------------------------------|--|--|---|--|--|--------------------------------------|--|--|
| CERTIFICATE OF DEATH   |  |                                   |  |  | 09810   |  |  |                                      |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY ANNE ARUNDEL MARYLAND   |  |                                   |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE MARYLAND b. COUNTY ANNE ARUNDEL |  |  |                                      |  |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ANNAPOLIS   |  |                                   | c. LENGTH OF STAY IN 1b 1 Hr. 10 Min.  |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ANNAPOLIS  |  |  | d. STREET ADDRESS                    |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U.S. NAVAL HOSPITAL, ANNAPOLIS, MARYLAND  |  |                                   |  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                    |  |  |                                      |  |  |
| 3. NAME OF DECEASED (Type or print) Baby Girl JOHNSON  |  |                                   | First Middle Last  |  | 4. DATE OF DEATH September 25 19 61   |  | Month Day Year   |                                      |  |  |
| 5. SEX FEMALE  |  | 6. COLOR OR RACE CAUC             |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH 25 September 1961         |  | 9. AGE (In years last birthday) 1 10 |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |  | 10b. KIND OF BUSINESS OR INDUSTRY |  | 11. BIRTHPLACE (County & State, or foreign country) ANNE ARUNDEL, MARYLAND   |   | 12. CITIZEN OF WHAT COUNTRY? UNITED STATES |  |                                      |  |  |
| 13. FATHER'S NAME JOHNSON, Eldon Lloyd   |  |                                   |  |  | 14. MOTHER'S MAIDEN NAME CROSS, Cathleen Mary   |  |  |                                      |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No   |  |                                   |  |  | 16. SOCIAL SECURITY NO. None  |  |  |                                      |  |  |
| 17. INFORMANT Eldon L. JOHNSON   |  |                                   |  |  | Address 100 Sycamore Court Annapolis, Maryland  |  |  |                                      |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 774X DUE TO Circulatory Collapse<br>(b) Prematurity<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                                   |  |  | INTERVAL BETWEEN ONSET AND DEATH  |  |  |                                      |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                                   |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                                      |  |  |                                      |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. 19  |  |                                   | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work et work |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)                       |                                      |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from 25 Sep. 19 61 to 25 Sep. 19 61, that (I) (we) last saw the deceased alive on 25 Sep. 19 61, and that death occurred at 4:25 AM from the causes and on the date stated above.   |  |                                   |  |  |   |  |  |                                      |  |  |
| 22a. SIGNATURE John McCann M.D.  |  |                                   |  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>   |  | 22b. DATE SIGNED   |                                      |  |  |
| 22c. PHYSICIAN'S NAME (Type) John McCann LT MC USNR  |  |                                   |  |  | 22d. ADDRESS U. S. NAVAL HOSPITAL, ANNAPOLIS, MARYLAND  |  |  |                                      |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL   |  |                                   | 23b. DATE THEREOF 9-26-61  |  | 23c. NAME OF CEMETERY OR CREMATORY US NAVAL ACADEMY   |  | 23d. LOCATION (City, town or county) ANNAPOLIS MD. (State) |                                      |  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor  |  |                                   |  |  | ADDRESS Annapolis, Md.  |  | 25a. REC'D BY REGISTRAR                                    |                                      | 25b. REGISTRAR'S SIGNATURE Arthur L. Kraus |  |
| DATE OCT 2 '61   |  |                                   |  |  |   |  |  |                                      |  |  |

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 9822 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09811

FOR STATE HEALTH DEPT.

TO DEPT. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

|  |                           |  |  |
|--|---------------------------|--|--|
| <b>1. PLACE OF DEATH</b><br>e. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>  |                           | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Same</u> b. COUNTY <u>Same</u>   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Brooklyn Park</u>   |                           | c. LENGTH OF STAY in 1b<br><u>13 years</u>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><u>5236 Wassina Ave. Wasena Ave.</u>   |                           | d. STREET ADDRESS<br><u>Same</u>   |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print) <u>Anna Carolyn Jones</u>  |                           | <b>4. DATE OF DEATH</b><br>Month <u>9/11/61</u> Day <u>19</u> Year <u>19</u>   |  |
| 5. SEX <u>F</u>  | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                  | 8. DATE OF BIRTH<br><u>4/4/1900</u>                |
| 9. AGE (In years last birthday)<br><u>61</u> yrs.  |                           | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u>   | IF UNDER 24 HRS.<br>Hours <u>  </u> Min. <u>  </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>  |                           | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>At Home</u>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><u>Baltimore, Md.</u>   |                           | 12. CITIZEN OF WHAT COUNTRY<br><u>USA</u>  |  |
| 13. FATHER'S NAME<br><u>Charles Swanberg</u>   |                           | 14. MOTHER'S MAIDEN NAME<br><u>Unknown</u>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><u>No</u>   |                           | 16. SOCIAL SECURITY NO.<br><u>None</u>   |  |
| 17. INFORMANT<br><u>Mr. Charles R. Jones Sr. (husband)</u>   |                           | Address <u>  </u>  |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]   |                           |  |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Self strangulation</u><br>DUE TO (b) <u>Mental condition</u><br>DUE TO (c) <u>  </u>  |                           |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>  |                           |  |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                           |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                           | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)<br><u>end to a pipe (water). Fastened one end of aplastic cord around her neck and the other</u> |  |
| 20c. TIME OF INJURY<br>Month, Day, Year <u>9/11/61</u> 19<br>Hour a.m. <u>3</u> p.m. <u>  </u>   |                           | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u>Home</u>  |                           | 20f. (City or town) (County) (State)<br><u>Brooklyn Park, A.A. Md.</u>   |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                           |  |  |
| ACTUAL SIGNATURE <u>Gustave H. Faubert</u>   |                           | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |
| EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>   |                           | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <u>9/11/61</u> DATE SIGNED   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |                           | 22b. DATE THEREOF<br><u>9-14-1961</u>  |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><u>Parkwood Cemetery</u>   |                           | 22d. LOCATION (City, town, or country) (State)<br><u>Parkville Md</u>  |  |
| 23. FUNERAL DIRECTOR<br><u>Lassahn Funeral Home</u>  |                           | 24a. REC'D BY REGISTRAR<br><u>SEP 14 '61</u>   |  |
| ADDRESS <u>7401 Belair Rd</u>  |                           | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Hume</u>  |  |

(M)

Line Arranged

Brooklyn Park

13 years

2nd

2200 - 2nd Ave. Brooklyn Park

2nd

Anna Carolyn Jones

9/17/51

W. 1300

1st Home

1st Home

Alternative

Charles's neighbors

Unknown

Home

at. Charles R. Jones Sr. (brother)

Self investigation

Medical condition

2nd

1st Home

9/17/51

Brooklyn Park, N.Y.

9/17/51

Charles R. Jones, Jr.

Charles R. Jones, Jr.

1st Home

Charles R. Jones, Jr.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |   |  |   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|---|--|---|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |   |  |   |  |   |  |   |  |  |  |
| 9823  |  |   |  |   |  | 09812   |  |   |  |  |  |
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <b>ANNE ARUNDEL COUNTY MARYLAND</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CROWNSVILLE</b><br>c. LENGTH OF STAY in 1b <b>11 y. 1 m. 4 d.</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>CROWNSVILLE STATE HOSP.</b> |  |   |  |   |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b><br>d. STREET ADDRESS <b>707 ALLEGANY PLACE</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |  |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print) <b>CLAUDIA MAE JONES</b>  |  |   |  |   |  | <b>4. DATE OF DEATH</b> <b>SEPTEMBER 16 1961</b>  |  |   |  |  |  |
| <b>5. SEX</b><br><b>FEMALE</b>  |  | <b>6. COLOR OR RACE</b><br><b>NEGRO</b> |  | <b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/><br><b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> |  | <b>8. DATE OF BIRTH</b><br><b>2/15/1910</b>   |  | <b>9. AGE</b> (In years last birthday) <b>51</b> yrs. |  | <b>IF UNDER 1 YEAR</b><br>Months Days Hours Min.                                 |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b>  |  |   |  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><b>-</b>  |  | <b>11. BIRTHPLACE</b> (County & State, or foreign country)<br><b>SOUTH CAROLINA</b>   |  |   | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><b>U. S. A.</b>                 |  |  |
| <b>13. FATHER'S NAME</b><br><b>FRANK GREEN</b>  |  |   |  |   |  | <b>14. MOTHER'S MAIDEN NAME</b><br><b>ELIZABETH GREEN</b>   |  |   |  |  |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown)<br><b>-</b>  |  |   |  | <b>16. SOCIAL SECURITY NO.</b><br><b>-</b>  |  | <b>17. INFORMANT</b><br><b>Dr. I. Turek</b> <b>Crownsville State Hosp.</b>  |  |   |  |  |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)]<br><b>Massive pulmonary embolism, acute</b><br><b>Syphilitic cardiocascular disease</b><br><b>General obesity</b>   |  |   |  |   |  |   |  |   |  | <b>INTERVAL BETWEEN ONSET AND DEATH</b><br><b>sudden</b><br><b>over 11 years</b> |  |
| <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>   |  |   |  |   |  |   |  |   |  |  |  |
| <b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)<br><input type="checkbox"/>   |  |   |  |   |  | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |  |  |
| <b>20c. TIME OF INJURY</b><br>Month, Day, Year<br>Hour a.m.<br>p.m.   |  |   | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |   |  | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)   |  |   | <b>20f. (City or town) (County) (State)</b>                            |  |  |
| <b>21. I certify that (I) (this hospital) attended the deceased from 12/8 1950, to 9/16 1961, that (I) (we) last saw the deceased alive on 9/16 1961, and that death occurred at 7:30 p.m. from the causes and on the date stated above.</b>  |  |   |  |   |  |   |  |   |  |  |  |
| <b>22a. SIGNATURE</b><br><b>L. Benedict, M.D.</b>   |  |   |  |   |  | <b>22b. DATE SIGNED</b><br><b>9/18/61</b>   |  |   | <b>22c. PHYSICIAN'S NAME (Type)</b><br><b>L. Benedict, M.D.</b>        |  |  |
| <b>22d. ADDRESS</b><br><b>Crownsville State Hospital, Crownsville, Md.</b>  |  |   |  |   |  |   |  |   |  |  |  |
| <b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b><br><b>Burial</b>   |  |   | <b>23b. DATE THEREOF</b><br><b>9-21-61</b>   |   |  | <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><b>St. Auburn Cem</b>  |  |   | <b>23d. LOCATION (City, town or county) (State)</b><br><b>Balto Md</b> |  |  |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b><br><b>Charles Horpu</b>   |  |   |  |   |  | <b>25a. REC'D BY REGISTRAR</b><br><b>SEP 25 '61</b>   |  |   | <b>25b. REGISTRAR'S SIGNATURE</b><br><b>Arthur S. Kraus</b>            |  |  |

08813

08823

M

I

Massive pulmonary embolism, acute  
Systolic cardiovascular disease

over 11  
years

General obesity

X

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9824

## CERTIFICATE OF DEATH

09813

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b><br>c. LENGTH OF STAY IN 1b <b>1 day</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Anne Arundel General Hospital</b>   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>RURAL - Edgewater</b><br>d. STREET ADDRESS <b>Rt-3, Box-126</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |
| 3. NAME OF DECEASED<br>(Type or print) <b>Harry C. KENNEY Sr.</b>  |  |   |  | 4. DATE OF DEATH<br>Month <b>Sept.</b> Day <b>11</b> Year <b>1961</b>  |  |   |  |
| 5. SEX <b>Male</b>   |  | 6. COLOR OR RACE <b>White</b>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 8. DATE OF BIRTH<br><b>April 25, 1897</b>                           |  |
| 9. AGE (In years last birthday) <b>64 yrs.</b>   |  | IF UNDER 1 YEAR<br>Months <b>0</b> Days <b>0</b>  |  | IF UNDER 24 HRS.<br>Hours <b>0</b> Min. <b>0</b>   |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RESTAURANT + BAR</b>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>RESTAURANT OWNER</b>  |  | 11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b> |  |
| 12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>   |  |   |  |  |  |   |  |
| 13. FATHER'S NAME <b>ISAIAH KENNEY</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME <b>DAISY THORPE</b>   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>  |  |   |  | 16. SOCIAL SECURITY NO. <b>NO</b>  |  |   |  |
| 17. INFORMANT <b>MRS. SUE E. KENNEY</b>  |  |   |  | Address <b>#2</b>  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral arteriosclerosis, generalized</b><br><b>443X</b> DUE TO (b) <b>Hypertensive cardiomyocardial disease</b><br>Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <b>and diabetes mellitus</b><br>DUE TO (c) <b></b> |  |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH <b>18 hours</b><br><b>years</b>    |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>  |  |   |  |  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. <b>19</b><br>p.m. <b></b>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)                                |  |
| 21. I certify that (I) <del>(X) deceased</del> attended the deceased from <b>Sept. 1, 1961</b> to <b>Sept. 10, 1961</b> , that (I) <del>(X)</del> saw the deceased alive on <b>Sept. 10, 1961</b> , and that death occurred at <b>8:03 AM</b> , from the causes and on the date stated above.  |  |   |  |  |  |   |  |
| 22a. SIGNATURE <b>Willard F. Smith</b>   |  |   |  | 22b. DATE SIGNED <b>8:03 AM</b>  |  |   |  |
| 22c. PHYSICIAN'S NAME (Type) <b>Dr. Willard F. Smith</b>   |  |   |  | 22d. ADDRESS <b>Shadyside, Md.</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>  |  | 23b. DATE THEREOF <b>9-14-61</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>MEADOWRIDGE CEM.</b>   |  | 23d. LOCATION (City, town or county) (State) <b>HOWARD Co MD.</b>   |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <b>JOHN M. TAYLOR SON ANNAPOLIS MD.</b>   |  |   |  | 25a. REC'D BY REGISTRAR <b>SEP 15 '61</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>                   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

08813

08813

(M)

(I)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

# ANNAPOLIS

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

9825

09814

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>             |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>  |  |   |  | c. LENGTH OF STAY IN 1b <b>11 days</b>  |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Anne Arundel General</b>   |  |   |  | d. STREET ADDRESS <b>Davidsonville</b>  |  |   |  |
| 3. NAME OF DECEASED<br>(Type or print) <b>George King</b>  |  |   |  | 4. DATE OF DEATH<br>Month <b>Sept.</b> Day <b>16</b> Year <b>19 61</b>  |  |   |  |
| 5. SEX <b>Male</b>   |  | 6. COLOR OR RACE <b>White</b>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>Feb. 23, 1887</b>                                   |  |
| 9. AGE (In years last birthday) <b>74</b> yrs.   |  | IF UNDER 1 YEAR<br>Months Days  |  | IF UNDER 24 HRS.<br>Hours Min.  |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>Tabacco</b>  |  | 11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>     |  |
| 12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>  |  |   |  |   |  |   |  |
| 13. FATHER'S NAME <b>George King</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME <b>Louise Ireland</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>  |  | 16. SOCIAL SECURITY NO. <b>218-36-3134</b>  |  | 17. INFORMANT <b>Mrs. Myrtle C. King, Wife; Same as # 2</b>   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>154X generalized carcinoma metastatic</b><br>DUE TO <b>Ca rectum</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b)<br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br>INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 yrs</b><br><b>3 yrs</b> |  |   |  |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |  |   |  |   |  |
| 20c. TIME OF INJURY<br>Hour a.m. <b>19</b> p.m.  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)                                    |  |
| 21. I certify that (I) <b>Dr. Samuel Borssuck</b> attended the deceased from <b>Sept. 16, 1961</b> to <b>Sept. 16, 1961</b> , that (I) <b>Dr. Borssuck</b> saw the deceased alive on <b>Sept. 16, 1961</b> , and that death occurred at <b>9:25 AM</b> from the causes and on the date stated above.   |  |   |  |   |  |   |  |
| 22a. SIGNATURE <b>Dr. Samuel Borssuck</b>  |  |   |  | 22b. DATE SIGNED <b>9/18/61</b>   |  |   |  |
| 22c. PHYSICIAN'S NAME (Type) <b>Dr. Samuel Borssuck</b>  |  |   |  | 22d. ADDRESS <b>Amos Garrett Blvd. Annapolis, Md.</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |  | 23b. DATE THEREOF <b>Sept. 19, 1961</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>   |  | 23d. LOCATION (City, town or county) (State) <b>Annapolis, Maryland</b> |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping Funeral Home</b>   |  |   |  | 25a. REC'D BY REGISTRAR <b>SEP 20 '61</b>   |  |   |  |
| ADDRESS <b>Annapolis, Md.</b>  |  |   |  | 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Knap</b>  |  |   |  |

MEDICAL CERTIFICATION

(M)

2222

00214

Anne Armandel

Libby

Anne Armandel

Annapolis

Libby

Annapolis

Anne Armandel General

George

King

Sept. 10

of

Feb. 23, 1887

White

White

Retired Farmer

Tabacco

Maryland

U. S.

Louise Ireland

George King

218-36-3134 Mrs. Myrtle G. King, wife; Same as # 2

no no

(T)

Sept. 10, 1901

Sept. 10, 1901

Sept. 10

Anne Armandel died, Annapolis, Md.

Dr. Samuel Johnson

Annapolis, Maryland

St. Mary's Cemetery

Sept. 10, 1901

burial

Sept 10 1901

Annapolis, Md.

Hopping (buried) here



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar or to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 9826 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **00815**

|   |                              |   |   |  |   |
|---|------------------------------|---|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>A.A.R.O.</b><br>MARYLAND  |                              |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MD</b> b. COUNTY <b>A.A.R.O.</b> |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>ANNAPOLIS - MD</b>   |                              |   | c. LENGTH OF STAY IN 1b   |  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>31 Calvert St.</b>   |                              |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                     |  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Charles</b> Middle <b>LowE</b> Last <b>LOWE</b>   |                              |   | 4. DATE OF DEATH<br>Month <b>Sept</b> Day <b>18</b> Year <b>1961</b>  |  |   |
| 5. SEX<br><b>M</b>  | 6. COLOR OR RACE<br><b>C</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>4-12-1912</b>  | 9. AGE (In years last birthday)<br><b>49</b> yrs.  | IF UNDER 1 YEAR<br>Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Laborer</b>   |                              | 10b. KIND OF BUSINESS OR INDUSTRY   |   | 11. BIRTHPLACE (State or foreign country)<br><b>Virginia</b>                               |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                              |   | 13. FATHER'S NAME<br><b>Unknown</b>   |  |   |
| 14. MOTHER'S MARDEN NAME<br><b>Unknown</b>  |                              |   | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown)<br><b>No</b>   |  |   |
| 16. SOCIAL SECURITY NO.<br><b>214-052334</b>  |                              |   | 17. INFORMANT<br><b>Lola Smith 618 2nd St</b>   |  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>434.4</b> DUE TO <b>Cadise</b><br>Conditions, if any, which gave rise to immediate cause (b)<br>(a), stating the underlying cause lost. DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>INTERVAL BETWEEN ONSET AND DEATH |                              |   |   |  |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>  |                              | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |  |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour <b>o. m.</b> <b>9/18</b> 1961<br>p. m.  |                              | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>Annapolis</b> |   |
| 20f. (City or town)<br><b>A.A.R.O.</b>  |                              | 20g. (County)<br><b>A.A.R.O.</b>  |   | 20h. (State)   |   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .   |                              |   |   |  |   |
| ACTUAL SIGNATURE<br><b>E. L. Linhardt</b>   |                              |   | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |   |
| EXAMINER'S NAME (Type)<br><b>E. L. Linhardt</b>   |                              |   | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                              |   | 22b. DATE THEREOF<br><b>9-21-1961</b>   |  |   |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Annapolis Neck</b>   |                              |   | 22d. LOCATION (City, town, or county)<br><b>Annapolis Md.</b>   |  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>William Reese H. Arma</b>  |                              |   | 24a. REC'D BY REGISTRAR<br>DATE <b>SEP 21 '61</b>   |  |   |
| 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Hume</b>   |                              |   | DATE SIGNED<br><b>9-18-61</b>   |  |   |

MEDICAL CERTIFICATION

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RECEIVED  
JAN 10 1964  
FBI - NEW YORK

URGENT

TO DIRECTOR  
FROM NEW YORK  
SUBJECT: [illegible]

Page 2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

9827

09816

|  |  |   |   |
|--|--|---|---|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <b>ANNE ARUNDEL</b> <b>MARYLAND</b>  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>A.A.</b>  |   |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>ANNAPOLIS</b>   |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>ANNAPOLIS</b>  |   |
| c. LENGTH OF STAY IN 1b<br><b>13 HOURS</b>   |  | d. STREET ADDRESS<br><b>72 EUCALYPTUS RD.</b>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>U.S. NAVAL HOSPITAL, ANNAPOLIS, MARYLAND</b>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| <b>3. NAME OF DECEASED</b><br>(Type or print)<br><b>Mary Catherine MAGEE</b>   |  | <b>4. DATE OF DEATH</b><br>Month <b>SEPTEMBER</b> Day <b>4</b> Year <b>19 61</b>  |   |
| <b>5. SEX</b><br><b>FEMALE</b>   | <b>6. COLOR OR RACE</b><br><b>CAUC.</b>  | <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/><br><b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>   | <b>8. DATE OF BIRTH</b><br><b>3 SEPTEMBER 1961</b>  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><b>None</b>  |  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><b>None</b>   | <b>9. AGE</b> (In years last birthday) yrs. <b>13</b> <b>22</b><br>If UNDER 1 YEAR<br>Months <b>13</b> Days <b>22</b> |
| <b>11. BIRTHPLACE</b> (County & State, or foreign country)<br><b>ANNE ARUNDEL, MARYLAND</b>  |  | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><b>UNITED STATES</b>   |   |
| <b>13. FATHER'S NAME</b><br><b>Patrick Henry MAGEE</b>   |  | <b>14. MOTHER'S MAIDEN NAME</b><br><b>Phyllis Louella TAYLOR</b>  |   |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b><br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>  |  | <b>16. SOCIAL SECURITY NO.</b><br><b>Patrick H. MAGEE</b>   |   |
| <b>17. INFORMANT</b><br><b>72 EUCALYPTUS ROAD, ANNAPOLIS, MARYLAND</b>   |  | <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory distress</b><br><b>762.5</b> DUE TO (b) <b>Prematurity</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) |   |
| <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>   |  | <b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)   |   |
| <b>20c. TIME OF INJURY</b><br>Month, Day, Year<br>Hour a.m. <b>19</b><br>p.m.  | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)   | <b>20f. (City or town)</b> (County) (State)   |
| <b>21. I certify that (I) (this hospital) attended the deceased from 3 September, 19 61 to 4 September 19 61, that (I) (we) last saw the deceased alive on 4 September 19 61, and that death occurred at 6:15 A.M. from the causes and on the date stated above.</b> |  |   |   |
| <b>22a. SIGNATURE</b><br><b>John M. CANN</b> M.D.  |  | <b>22b. DATE SIGNED</b><br><b>5 SEPTEMBER 1961</b>  |   |
| <b>22c. PHYSICIAN'S NAME</b> (Type)<br><b>J. MC CANN, LT MC USNR</b>   |  | <b>22d. ADDRESS</b><br><b>U. S. NAVAL HOSPITAL, ANNAPOLIS, MD.</b>  |   |
| <b>23a. BURIAL, CREMATION, or other disposition</b><br><b>BURIAL</b>   | <b>23b. DATE THEREOF</b><br><b>SEPT 9, 1961</b>  | <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><b>ST. ANTHONY</b>   | <b>23d. LOCATION</b> (City, town or county) (State)<br><b>SARANAC MICH</b>  |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b><br><b>John M. Taylor, Son Annapolis Md</b>   |  | <b>25a. REC'D BY REGISTRAR</b><br><b>SEP 8 '61</b>  |   |
| <b>25b. REGISTRAR'S SIGNATURE</b><br><b>Arthur L. Kraus</b>  |  |   |   |

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1-800-368-2840

U.S. MARINE HOSPITAL, MARINE CORPS, 1942

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1961 025 77 002 2

Ernst H. Young

17 February 1999

Respectfully,  
Sincerely,

1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.

to be reduced to:

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THEY ARE THE

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John M. Taylor and Company

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

9828

## CERTIFICATE OF DEATH

|  |                               |  |                                       |  |   |  |   |
|--|-------------------------------|--|---------------------------------------|--|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>   |                               |  |                                       | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Calvert</b> |   |  |   |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>  |                               |  |                                       | c. LENGTH OF STAY IN 1b <b>3 days</b>  |   |  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Anne Arundel General Hospital</b>  |                               |  |                                       | d. STREET ADDRESS <b>Solemons Box-38</b>   |   |  |   |
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last <b>Ronald Mark MANSUETI</b>   |                               |  |                                       | 4. DATE OF DEATH Month Day Year <b>Sept. 9 19 61</b>   |   |  |   |
| 5. SEX <b>Male</b>   | 6. COLOR OR RACE <b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>Sept. 6, 1961</b> |  | 9. AGE (In years last birthday) yrs. <b>2</b> | IF UNDER 1 YEAR Months <b>2</b> Days <b>22</b>   | IF UNDER 24 HRS. Hours <b>22</b> Min. <b>42</b> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |                               | 10b. KIND OF BUSINESS OR INDUSTRY  |                                       | 11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>  |   | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>   |   |
| 13. FATHER'S NAME <b>Romeo John Mansueti</b>   |                               |  |                                       | 14. MOTHER'S MAIDEN NAME <b>Alice Jane O'Brien</b>   |   |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)  |                               | 16. SOCIAL SECURITY NO. (If yes give war or dates of service)  |                                       | 17. INFORMANT <b>Hospital records.</b> Address   |   |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>768.5</b> DUE TO <b>Meningitis + ? Septicemia</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Premature Infant (New Born)</b><br>(c) DUE TO |                               |  |                                       |  |   | INTERVAL BETWEEN ONSET AND DEATH <b>Few Hours</b>  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)   |                               |  |                                       |  |   | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                       |  |   |  |   |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>  |                               | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |                                       | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)   |   |
| 21. I certify that (I) <b>(his brother)</b> attended the deceased from <b>Sept. 6, 1961</b> to <b>Sept. 9, 1961</b> , that (I) <b>(we)</b> saw the deceased alive on <b>Sept. 8, 1961</b> , and that death occurred at <b>2:20 A.M.</b> from the causes and on the date stated above.  |                               |  |                                       |  |   |  |   |
| 22a. SIGNATURE <b>Philip Briscoe</b> M.D.  |                               |  |                                       | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>            |   | 22b. DATE SIGNED <b>9/9/61</b>   |   |
| 22c. PHYSICIAN'S NAME (Type) <b>Philip Briscoe</b>   |                               |  |                                       | 22d. ADDRESS <b>95 Cathedral St., Annapolis, Md.</b>   |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |                               | 23b. DATE THEREOF <b>Sept. 11, 61</b>  |                                       | 23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>  |   | 23d. LOCATION (City, town or county) (State) <b>Annapolis, Md.</b>                             |   |
| 24 FUNERAL DIRECTOR'S SIGNATURE <b>Hopping Funeral Home</b> ADDRESS <b>Annapolis, Md.</b>  |                               |  |                                       | 25a. REC'D BY REGISTRAR <b>SEP 13 '61</b> DATE   |   | 25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>  |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

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July

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*Handwritten signature*

*Handwritten signature*

Hoping Funeral Home      St. Mary's Cemetery      Annapolis, Md.  
Annapolis, Md.



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please indicate the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |                                 |  |   |  |  |  |  |  |   |  |
|--|--|---------------------------------|--|---|--|--|--|--|--|---|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |                                 |  |   |  |  |  |  |  |   |  |
| 9829 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09818   |  |                                 |  |   |  |  |  |  |  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Anne Arundel</u>   |  |                                 |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>e. STATE <u>Md.</u> b. COUNTY <u>P. Geo.</u>  |  |  |  |   |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>  |  |                                 |  |   |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u>   |  |  |  |   |  |
| c. LENGTH OF STAY IN 1b  |  |                                 |  |   |  | d. STREET ADDRESS <u>1700 Kenilworth Avenue</u>  |  |  |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)   |  |                                 |  |   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>King</u> Middle <u>Matthews</u> Last <u>Matthews</u>   |  |                                 |  |   |  | 4. DATE OF DEATH<br>Month <u>9</u> Day <u>3</u> Year <u>1961</u>   |  |  |  |   |  |
| 5. SEX <u>Male</u>   |  | 6. COLOR OR RACE <u>Colored</u> |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>10-8-1921</u>  |  | 9. AGE (in years last birthday) <u>38</u> yrs.   |  | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u> |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sanitor</u>   |  |                                 |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>  |  | 11. BIRTHPLACE (State or foreign country) <u>Md.</u>   |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |  |
| 13. FATHER'S NAME <u>Thomas Matthews sr.</u>   |  |                                 |  |   |  | 14. MOTHER'S MAIDEN NAME <u>Mary O. King</u>   |  |  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)  |  |                                 |  |   |  | 16. SOCIAL SECURITY NO. <u>  </u>  |  | 17. INFORMANT <u>Thomas Matthews sr.</u>   |  | Address <u>  </u>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Drowning</u><br><u>929.8</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>  </u><br>(c) <u>  </u>   |  |                                 |  |   |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |  |                                 |  |   |  |  |  |  |  |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  |                                 |  |   |  | 2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><u>Dived over the side of boat into the water to retrieve a rubber ball that had fallen from his boat.</u> |  |  |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour <u>  </u> e.m. <u>  </u> p.m. <u>  </u><br><u>8/31 1961</u>  |  |                                 |  |   |  | 2Dd. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Oyster Creek nr. Annapolis</u> |  | 20f. (City or town) <u>A.A.</u> (County) <u>  </u> (State) <u>Md.</u>             |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                                 |  |   |  |  |  |  |  |   |  |
| ACTUAL SIGNATURE <u>W. J. York</u>   |  |                                 |  |   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |  |  |   |  |
| EXAMINER'S NAME (Type) <u>  </u>   |  |                                 |  |   |  | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>   |  |  |  |   |  |
| DATE SIGNED <u>9-3-61</u>  |  |                                 |  |   |  | DEPUTY MEDICAL EXAMINER <input type="checkbox"/>   |  |  |  |   |  |
| Address (Street, city, town, or county) <u>  </u>  |  |                                 |  |   |  | 22d. LOCATION (City, town, or country) <u>Washington DC.</u> (State) <u>  </u>   |  |  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>  </u>  |  | 22b. DATE THEREOF <u>9-4-61</u> |  | 22c. NAME OF CEMETERY OR CREMATORY <u>H.S. Washington Son</u>   |  |  |  | 22d. ADDRESS <u>4925 Deans Ave. N.E. Wash. D.C.</u>  |  | 24a. REC'D BY REGISTRAR <u>SEP 5 '61</u>  |  |
| 23. FUNERAL DIRECTOR <u>  </u>   |  |                                 |  |   |  | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>   |  |  |  |   |  |

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(M)

(I)

Drumming

John White

may be relied upon by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. No. 09819

|  |                           |  |                                     |
|--|---------------------------|--|-------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Anne Arundel</u> MARYLAND  |                           | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Md.</u> b. COUNTY <u>Anne Arundel</u>               |                                     |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seatons</u>  |                           | c. LENGTH OF STAY IN 1b <u>24 years</u>  |                                     |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION   |                           | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                     |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Charles</u> Middle <u>Mowre</u> Last <u>Medley</u>   |                           | 4. DATE OF DEATH<br>Month <u>Sept</u> Day <u>25</u> Year <u>1961</u>   |                                     |
| 5. SEX <u>M</u>  | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Oct 20/1878</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Watchman Coal Co.</u>   |                           | 11. BIRTHPLACE (State or foreign country) <u>Georgia</u>   |                                     |
| 13. FATHER'S NAME <u>Joel P. Medley</u>  |                           | 14. MOTHER'S MAIDEN NAME <u>Nancy Ann Moon</u>   |                                     |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>  |                           | 16. SOCIAL SECURITY NO. <u>Informant</u>   |                                     |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Cardiac Failure</u><br>491X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost:<br>(b) <u>Acute Bronchopneumonia</u> DUE TO<br>(c) <u>4 days</u> |                           | INTERVAL BETWEEN ONSET AND DEATH <u>suddenly</u>   |                                     |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized arteriosclerosis - Sclerosis</u>  |                           | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                     |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                     |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. 19  |                           | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work  |                                     |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                           | 20f. (City or town) (County) (State)   |                                     |
| 21. I certify that I attended the deceased from <u>Sept 20, 1961</u> to <u>Sept 25, 1961</u> that I last saw the deceased alive on <u>Sept 24, 1961</u> and that death occurred at <u>11:15 A.M.</u> from the causes and on the date stated above.   |                           |  |                                     |
| ACTUAL SIGNATURE <u>DR JOSEPH LIPSKEY</u>  |                           | DATE SIGNED <u>9/25/61</u>   |                                     |
| PHYSICIAN'S NAME (Type) <u>DR JOSEPH LIPSKEY</u>   |                           | ADDRESS (Street, city or town, state) <u>Seatons Md</u>  |                                     |
| 22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>   |                           | 22b. LOCATION (City, town, or county) (State) <u>Annapolis, Maryland</u>   |                                     |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u>   |                           | 24a. REC'D BY REGISTRAR <u>Arthur S. Thoms</u>   |                                     |
| ADDRESS <u>Annapolis, Md.</u>  |                           | DATE <u>SEP 28 '61</u>   |                                     |

USA

Henry and son

Joel F. Kelley

Sept. 27, 1901 Highest Marshal Court. American, Maryland

Attorney General, Washington, D.C.

9831

## CERTIFICATE OF DEATH

Reg. Dist. No.

09820

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>AA</u>                       |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>PINE GROVE VILLAGE</u>   |  |   |  | c. LENGTH OF STAY IN 1b<br><u>23 YRS</u>  |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>119 NORMAN ROAD</u>  |  |   |  | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>X PINE GROVE VILLAGE</u>   |  |  |  |
| f. STREET ADDRESS<br><u>119 NORMAN ROAD</u>   |  |   |  | g. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br><u>CHARLES ALBERT MILLER</u>  |  |   |  | 4. DATE OF DEATH<br>Month Day Year<br><u>SEPT. 12 1961</u>  |  |  |  |
| 5. SEX<br><u>MALE</u>   |  | 6. COLOR OR RACE<br><u>WHITE</u>              |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>FEB 8. 1890</u>                                 |  |
| 9. AGE (In years last birthday)<br><u>71</u> yrs.   |  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min. |  | 11. IF UNDER 24 HRS.  |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>                          |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>ENGINEER</u>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>MAINTENANCE</u>   |  | 11. BIRTHPLACE (State or foreign country)<br><u>MARYLAND</u>           |  |
| 13. FATHER'S NAME<br><u>OTTO MILLER</u>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Augusta Selman</u>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><u>NO</u>   |  |   |  | 16. SOCIAL SECURITY NO.<br><u>214 01-5482</u>   |  | 17. INFORMANT<br>Address<br><u>MRS. CHARLES MILLER</u> <u>SAMR</u>     |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u><br><u>4221</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ |  |   |  |   |  |  |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br><u>19</u>  |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  |
| 20f. (City or town)<br><u>PASADENA, MARYLAND</u>  |  |   |  | 20g. (County) (State)   |  |  |  |
| 21. I certify that I attended the deceased from <u>JUNE</u> , 19 <u>60</u> , to <u>SEPT. 12</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>SEPT. 11</u> , 19 <u>61</u> , and that death occurred at <u>4:00 P.</u> M, from the causes and on the date stated above.  |  |   |  |   |  |  |  |
| ACTUAL SIGNATURE<br><u>J. Brady Smith</u>   |  |   |  | ADDRESS (Street, city or town, state)<br><u>8471 FT. SMALLWOOD ROAD</u>   |  |  |  |
| DATE SIGNED<br><u>9/12/61</u>   |  |   |  | M.D.<br><u>PASADENA, MARYLAND</u>   |  |  |  |
| PHYSICIAN'S NAME (Type)<br><u>W. BRADY SMITH</u>  |  |   |  | DATE<br><u>SEP 15 '61</u>   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>SEP 15 - 61</u>   |  | 22b. DATE THEREOF<br><u>9-15-61</u>           |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>EDGAR HILL</u>   |  | 22d. LOCATION (City, town, or county) (State)<br><u>BALTIMORE</u>      |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>W. Brady Smith</u>   |  |   |  | 24a. REC'D BY REGISTRAR<br>DATE<br><u>SEP 15 '61</u>  |  | 24b. REGISTRAR'S SIGNATURE<br><u>William J. Smith</u>                  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1951

100820

|   |  |   |  |  |  |   |  |  |  |                                      |  |
|---|--|---|--|--|--|---|--|--|--|--------------------------------------|--|
| 1. NAME OF DECEASED<br>W. J. BROWN              |  | 2. SEX<br>Male                              |  | 3. AGE<br>45                                     |  | 4. DATE OF BIRTH<br>10-15-1906                |  | 5. PLACE OF BIRTH<br>BALTIMORE, MARYLAND               |  | 6. OCCUPATION<br>Salesman            |  |
| 7. MARITAL STATUS<br>Married                    |  | 8. RACE<br>White                            |  | 9. RELIGION<br>Roman Catholic                    |  | 10. EDUCATION<br>High School                  |  | 11. SOCIAL SECURITY NUMBER<br>1-123-456789             |  | 12. DATE OF DEATH<br>11-10-1951      |  |
| 13. PLACE OF DEATH<br>Home                      |  | 14. CAUSE OF DEATH<br>Myocardial Infarction |  | 15. MANNER OF DEATH<br>Natural                   |  | 16. MEDICAL HISTORY<br>Hypertension, Diabetes |  | 17. PRESENT ILLNESS<br>Chest pain, shortness of breath |  | 18. TIME OF DEATH<br>11:00 AM        |  |
| 19. SIGNATURE OF PHYSICIAN<br>J. D. Smith, M.D. |  | 20. SIGNATURE OF DECEASED<br>W. J. Brown    |  | 21. SIGNATURE OF WITNESSES<br>A. B. C., D. E. F. |  | 22. SIGNATURE OF CLERK<br>G. H. I.            |  | 23. SIGNATURE OF REGISTRAR<br>J. K. L.                 |  | 24. SIGNATURE OF CORONER<br>M. N. O. |  |

11

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, AND A COPY OF THE SAME IS TO BE FURNISHED TO THE COUNTY CLERK OF THE COUNTY IN WHICH THE DECEASED RESIDED AT THE TIME OF HIS OR HER DEATH.



1  
FOR STATE  
HEALTH DEPT.

TO DEPT. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 18 File # 299  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
9832 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09821

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>           |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Earleigh Heights</b>   |  |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Severna Park - Earleigh Heights</b>                                |  |  |  |
| c. LENGTH OF STAY IN 1b<br><b>1</b>   |  |  |  | d. STREET ADDRESS<br><b>Spring Hill - Earleigh Heights</b>  |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Anne Arundel Hospital</b>  |  |  |  | e. IS RESIDENCE ON A FARM? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>JOHN</b>   |  | First  |  | Middle  |  | Last   |  |
| 5. SEX<br><b>Male</b>   |  | 6. COLOR OR RACE<br><b>Colored</b>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>   |  | 8. DATE OF BIRTH<br><b>Jan 7 - 1925</b>            |  |
| 9. AGE (In years last birthday)<br><b>36</b> yrs.   |  | 10. IF UNDER 1 YEAR<br>Months <b>3</b> Days <b>10</b> Hours <b>10</b> Min.   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Virginia</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>      |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Laborer</b>   |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| 13. FATHER'S NAME<br><b>John F. Monroe</b>  |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Martha Roots</b>   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |  |  |  | 16. SOCIAL SECURITY NO.<br><b>1-3-61</b>  |  | 17. INFORMANT<br><b>Christine Monroe Wife</b>      |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Fracture of neck</b><br>820X DUE TO (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Acute alcoholism</b> |  |  |  |   |  |  |  |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |   |  |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>Passenger getting off bus apparently fell under it</b> |  |  |  |
| 20c. TIME OF INJURY<br>Hour <b>7:55</b> p.m. <b>9/30/1961</b>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>Rt. 2 - Ritchie Hwy. Earleigh Heights, Anne Arun.</b>                        |  | 20f. (City or town) (County) (State)<br><b>Md.</b> |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>                             |  |  |  |   |  |  |  |
| ACTUAL SIGNATURE<br><b>Peter W. Rieckert</b>  |  |  |  | CHIEF MEDICAL EXAMINER<br><b>Medical Investigator X</b>   |  |  |  |
| EXAMINER'S NAME (Type)<br><b>Peter W. Rieckert, M.D.</b>  |  |  |  | DEPUTY MEDICAL EXAMINER <input type="checkbox"/>  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  |  |  | 22b. DATE THEREOF<br><b>10-5-61</b>   |  |  |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>First Baptist</b>  |  |  |  | 22d. LOCATION (City, town, or country) (State)<br><b>Earleigh Heights-a.a. Co Md</b>  |  |  |  |
| 23. FUNERAL DIRECTOR<br><b>Rayner Sanders 217 E Preston St</b>  |  |  |  | 24b. REC'D BY REGISTRAR<br><b>Arthur S. Kraus</b>   |  |  |  |
| 24a. DATE<br><b>OCT 6 '61</b>   |  |  |  | 24c. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>  |  |  |  |

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

9833

Item 12 Film G295 9/20/61 jvk

09822

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <b>AA</b> <span style="float: right;">MARYLAND</span><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BROOKLYN</b><br>c. LENGTH OF STAY IN 1b<br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>308 Church ST</b> |  |   |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>AA</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BROOKLYN</b><br>d. STREET ADDRESS <b>308 Church ST.</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print) <b>DOMINIC</b><br>First Middle Last   |  | <b>4. DATE OF DEATH</b><br><b>9 12 1961</b><br>Month Day Year   |  | <b>5. SEX</b> <b>M</b><br><b>6. COLOR OR RACE</b> <b>W</b><br><b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br><b>8. DATE OF BIRTH</b> <b>1-21-80</b><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  |  |  |
| <b>9. AGE</b> (In years last birthday) <b>81</b> yrs.<br>IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.  |  | <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Truck Driver</b><br><b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><b>11. BIRTHPLACE</b> (Country & State or foreign country) <b>Italy</b><br><b>12. CITIZEN OF WHAT COUNTRY?</b> <b>Italy</b> |  | <b>13. FATHER'S NAME</b> <b>DiSquale</b><br><b>14. MOTHER'S MAIDEN NAME</b> <b>Josephine ?</b>  |  |  |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b><br>(If yes give war or dates of service)   |  | <b>16. SOCIAL SECURITY NO.</b><br><b>17. INFORMANT</b> <b>Family - Same</b><br>Address  |  | <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Ca of the stomach</b><br>151X DUE TO<br>Conditions, if any, which gave rise to immediate cause (b)<br>(a), stating the underlying cause last. DUE TO (c)   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |  |   |  | <b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | <b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |  |  |
| <b>20c. TIME OF INJURY</b><br>Month, Day, Year<br>Hour a.m. p.m.  |  | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)<br><b>20f. (City or town)</b> (County) (State)  |  |  |  |
| <b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>9-21, 1959</b> , to <b>9-12, 1961</b> , that (I) (we) last saw the deceased alive on <b>9-9, 1961</b> , and that death occurred at <b>5:30 P.M.</b> , from the causes and on the date stated above.   |  |   |  |   |  |  |  |
| <b>22a. SIGNATURE</b><br><b>Eugene Schnitzer</b><br>M.D.  |  | <b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/><br><b>22d. ADDRESS</b> <b>3904 S. Hanover St., Balt. 25, Md.</b>   |  | <b>22b. DATE SIGNED</b><br><b>9-13-61</b>   |  |  |  |
| <b>22c. PHYSICIAN'S NAME (Type)</b><br><b>Eugene Schnitzer M.D.</b>   |  | <b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>B</b><br><b>23b. DATE THEREOF</b> <b>9-16-61</b><br><b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Cathedral</b><br><b>23d. LOCATION (City, town, or county)</b> <b>Baltimore</b> (State)   |  |   |  |  |  |
| <b>24 FUNERAL DIRECTOR'S SIGNATURE</b><br><b>McClully Funeral Homes</b><br>ADDRESS <b>130 E. Fort Ave #30</b>   |  | <b>25a. REC'D BY REGISTRAR</b><br><b>DATE SEP 15 '61</b>  |  | <b>25b. REGISTRAR'S SIGNATURE</b><br><b>Arthur S. Kraus</b>   |  |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If 24 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, sign and date 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Pages 3 and 4 should be retained by the funeral director. After this certificate has been signed by the attending physician and completed in and by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |   |  |   |  |   |  |  |  |  |  |
|--|--|---|--|---|--|---|--|--|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |   |  |   |  |   |  |  |  |  |  |
| CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |  |  |  |  |
| 9834 09823   |  |   |  |   |  |   |  |  |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>   |  |   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> |  |  |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis</b>   |  |   |  |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis</b>  |  |  |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Anne Arundel General Hospital</b>   |  |   |  |   |  | d. STREET ADDRESS<br><b>29 Dean St.</b>   |  |  |  |  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Mannie</b>  |  |   |  |   |  | 4. DATE OF DEATH<br>Month <b>Sept.</b> Day <b>22</b> Year <b>1961</b>   |  |  |  |  |  |
| 5. SEX<br><b>Female</b>  |  | 6. COLOR OR RACE<br><b>Negro</b>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>Feb. 9, 1907</b>   |  | 9. AGE (In years last birthday)<br><b>54</b> yrs.                      |  | IF UNDER 1 YEAR<br>Months <b>54</b> Days <b>22</b> Hours <b>19</b> Min.                |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Domestic</b>   |  |   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Maryland</b> |  | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.</b>   |  |
| 13. FATHER'S NAME<br><b>James Diggs Sr.</b>  |  |   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Elizabeth Diggs</b>  |  |  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>219-30-2251</b>  |  |   |  |   |  | 17. INFORMANT<br><b>Clarence M. Gray</b> Address <b>29 Dean St.</b>   |  |  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute gastric dilatation due to hiatus hernia and intestinal obstruction (duodenum).</b><br>561.4 DUE TO<br>Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b)<br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>24 hrs.</b> |  |   |  |   |  |   |  |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m.<br>p.m.<br><b>19</b>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town)<br><b>Annapolis</b>   |  | (County)<br><b>Anne Arundel</b>  |  | (State)<br><b>Md.</b>  |  |
| 21. I certify that (I) <b>(the house)</b> attended the deceased from <b>Sept. 20, 1961</b> to <b>Sept. 21, 1961</b> , that (I) <b>(we)</b> saw the deceased alive on <b>Sept. 21, 1961</b> , and that death occurred at <b>8:33 A.M.</b> from the causes and on the date stated above.   |  |   |  |   |  |   |  |  |  |  |  |
| 22a. SIGNATURE<br><b>Lionel H. Mapp</b>  |  |   |  |   |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                            |  | 22b. DATE SIGNED<br><b>9/22/61</b>                                     |  |  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Lionel H. Mapp</b>  |  |   |  |   |  | 22d. ADDRESS<br><b>20 Dean St., Annapolis, Md.</b>  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE THEREOF<br><b>9-25-1961</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Brewer Hill</b>  |  | 23d. LOCATION (City, town or county) (State)<br><b>Annapolis Md.</b>  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>William Reese</b>   |  |   |  |   |  | ADDRESS<br><b>Annapolis Md.</b>   |  | 25a. REC'D BY REGISTRAR<br><b>SEP 26 '61</b>                           |  | 25b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kline</b>                                   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

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|--|--|---|--|---|--|--|--|--|--|
| <b>1. PLACE OF DEATH</b><br>e. COUNTY <b>ANNE ARUNDEL</b> <b>MARYLAND</b>  |  |   |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission)<br>e. STATE <b>MARYLAND</b> b. COUNTY <b>ANNE ARUNDEL</b>          |  |  |  |  |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>ANNAPOLIS</b>   |  |   |  | c. LENGTH OF STAY IN 1b<br><b>24 DAYS</b>   |  |  |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>U.S. NAVAL HOSPITAL, ANNAPOLIS, MARYLAND</b>  |  |   |  | d. STREET ADDRESS<br><b>84 CONDUIT STREET</b>   |  |  |  |  |  |
| <b>3. NAME OF DECEASED</b> (Type or print)<br><b>Mary Ruth MURPHY</b>  |  |   |  | <b>4. DATE OF DEATH</b> Month <b>SEPTEMBER</b> Day <b>5</b> Year <b>19 61</b>   |  |  |  |  |  |
| <b>5. SEX</b><br><b>FEMALE</b>   |  | <b>6. COLOR OR RACE</b><br><b>CAUC.</b>   |  | <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | <b>8. DATE OF BIRTH</b><br><b>1 DECEMBER 1892</b>                              |  |  |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b>   |  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b>  |  | <b>11. BIRTHPLACE</b> (County & State, or foreign country)<br><b>ANNAPOLIS, MARYLAND</b>  |  | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><b>UNITED STATES</b>                    |  |  |  |
| <b>13. FATHER'S NAME</b><br><b>Myers Thomas BOUCHER</b>  |  |   |  | <b>14. MOTHER'S MAIDEN NAME</b><br><b>Elizabeth Estell HOPKINS</b>  |  |  |  |  |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>NO</b>   |  |   |  | <b>17. INFORMANT</b><br><b>J. LLOYD HOPKINS</b>   |  |  |  |  |  |
| <b>16. SOCIAL SECURITY NO.</b>   |  |   |  | <b>208 Mc KENDREE AVENUE</b><br><b>ANNAPOLIS, MARYLAND</b>  |  |  |  |  |  |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Left Ventricular Failure</b><br>DUE TO (b) <b>Arteriosclerotic Heart Disease</b><br>DUE TO (c) <b>420.0</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |  |  | <b>INTERVAL BETWEEN ONSET AND DEATH</b><br><b>12 hours</b><br><b>1 year</b>                              |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Carcinoma of the Stomach with metastases</b>   |  |   |  |   |  |  |  | <b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| <b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |  |  |
| <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour e.m. p.m. <b>19</b>  |  | <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)   |  | <b>20f. (City or town) (County) (State)</b>                                    |  |  |  |
| <b>21. I certify that (I) (this hospital) attended the deceased from 12 August 1961 to 5 September 1961, that (I) (we) last saw the deceased alive on 5 September 1961, and that death occurred at 7:58 PM, from the causes and on the date stated above.</b>  |  |   |  |   |  |  |  |  |  |
| <b>22a. SIGNATURE</b><br><b>R.G.W. WILLIAMS, Jr., CDR MC USN</b>   |  |   |  | <b>22b. DATE SIGNED</b><br><b>5 SEPTEMBER 1961</b>  |  | <b>22c. PHYSICIAN'S NAME (Type)</b><br><b>R.G.W. WILLIAMS, Jr., CDR MC USN</b> |  |  |  |
| <b>22d. ADDRESS</b><br><b>U. S. NAVAL HOSPITAL, ANNAPOLIS, MD.</b>   |  |   |  |   |  |  |  |  |  |
| <b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b><br><b>BURIAL</b>  |  | <b>23b. DATE THEREOF</b><br><b>Sept. 8, 1961</b>  |  | <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><b>U.S. NAVAL ACADEMY</b>  |  | <b>23d. LOCATION (City, town or county) (State)</b><br><b>ANNAPOLIS MD</b>     |  |  |  |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b><br><b>John M. Taylor</b>   |  |   |  | <b>25a. REC'D BY REGISTRAR</b><br><b>SEP 8 1961</b>   |  | <b>25b. REGISTRAR'S SIGNATURE</b><br><b>Arthur S. Kraus</b>                    |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

|   |   |   |   |
|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Anne Arundel</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis</b><br>c. LENGTH OF STAY IN 1b<br><b>MARYLAND</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>Anne Arundel General Hospital</b>     |   | 2. USUAL RESIDENCE (Where deceased lived, if institutional, include date of admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Anne Arundel</b><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Dorsey Heights, Old Solomons Island</b><br>d. STREET ADDRESS<br><b>Rd.</b><br>a. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Katherine</b><br>First Middle Last<br><b>PARKER</b>  |   | 4. DATE OF DEATH<br>Month Day Year<br><b>9 29 1961</b>  |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>Colored</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><b>3-18-05</b>            |
| 9. AGE (In years last birthday)<br><b>56 yrs.</b>   |   | IF UNDER 1 YEAR<br>Months Days<br><b>9 29</b>   | IF UNDER 24 HRS.<br>Hours Min.<br><b>1961</b> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Maryland</b>  |   |
| 11. BIRTHPLACE (County, State, or foreign country)<br><b>U.S.A.</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13. FATHER'S NAME<br><b>Cemo Collins</b>  |   | 14. MOTHER'S MAIDEN NAME<br><b>Druzela Brown</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)<br><b>171X</b>   |   | 16. SOCIAL SECURITY NO.<br><b>77edieparker Anna Md</b>  |   |
| 17. INFORMANT<br><b>77edieparker Anna Md</b>  |   | Address   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cervix to spread</b><br><b>171X</b> DUE TO (b) <b>in vital structures</b><br>Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) <b>uremia</b> |   | INTERVAL BETWEEN ONSET AND DEATH  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m.<br>p.m.<br><b>19</b>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)          |
| 21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on.....19....., and that death occurred at.....M, from the causes and on the date stated above.  |   |   |   |
| 22a. SIGNATURE<br><b>Aris T. Allen</b><br>M.D.  |   | 22b. DATE SIGNED<br><b>OCT 2 61</b>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Aris T. Allen</b>  |   | 22d. ADDRESS<br><b>Cathedral Street, Annapolis, Maryland</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |   | 23b. DATE THEREOF<br><b>10-4-1961</b>   |   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Chews Memorial</b>   |   | 23d. LOCATION (City, town or county) (State)<br><b>West River Md</b>  |   |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>William Reese</b>  |   | 25. REC'D BY REGISTRAR<br><b>William Reese</b>  |   |
| 25a. ADDRESS<br><b>Annapolis Md</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>William Reese</b>  |   |

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TO HOSPITAL FOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

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|  |                           |  |                                  |
|--|---------------------------|--|----------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <i>Anne Arundel</i> MARYLAND  |                           | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <i>md</i> b. COUNTY <i>Anne Arundel</i>                |                                  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Round Bay</i>  |                           | c. LENGTH OF STAY IN 1b  |                                  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>606 Laurel Rd.</i>   |                           | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                  |
| 3. NAME OF DECEASED (Type or print) <i>Alice Lee</i> (First Middle Last)   |                           | 4. DATE OF DEATH <i>9-26-61</i> (Month Day Year)   |                                  |
| 5. SEX <i>F.</i>   | 6. COLOR OR RACE <i>W</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>9-6-1890</i> |
| 9. AGE (In years lost birthday) <i>71</i> yrs.   |                           | 10. IF UNDER 1 YEAR Months Days  | 11. IF UNDER 24 HRS. Hours Min.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>   |                           | 10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>  |                                  |
| 11. BIRTHPLACE (State or foreign country) <i>Balto. Md.</i>  |                           | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>  |                                  |
| 13. FATHER'S NAME <i>Robert Lee Jones</i>  |                           | 14. MOTHER'S MAIDEN NAME <i>Margaret Ella Martin</i>   |                                  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)   |                           | 16. SOCIAL SECURITY NO. (If yes, give war or date of service)  |                                  |
| 17. INFORMANT <i>M. Charles F. Place</i>   |                           | Address <i>606 Laurel Rd.</i>  |                                  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>MYOCARDIAL INFARCTION</i><br>420.1 DUE TO<br>Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <i>Arteriosclerotic Cardio-Vascular</i><br>DUE TO (c) <i>disease</i> |                           | INTERVAL BETWEEN ONSET AND DEATH   |                                  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                           | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                  |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>  |                           | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                           | 20f. (City or town) (County) (State)   |                                  |
| 21. I certify that (I) (this hospital) attended the deceased from <i>1959</i> to <i>1961</i> , that (I) (we) last saw the deceased alive on <i>9-</i> 19, and that death occurred at <i>2 P.M.</i> from the causes and on the date stated above.   |                           |  |                                  |
| 22a. SIGNATURE <i>Robert R. Hahn</i> M.D.  |                           | 22b. DATE SIGNED   |                                  |
| 22c. PHYSICIAN'S NAME (Type) <i>Robert R. Hahn</i>   |                           | 22d. ADDRESS <i>Severna Park md</i>  |                                  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>  |                           | 23b. DATE THEREOF <i>9-29-61</i>   |                                  |
| 23c. NAME OF CEMETERY OR CREMATORY <i>Woodlawn Cemetery</i>  |                           | 23d. LOCATION (City, town, or county) (State) <i>Woodlawn, Md.</i>   |                                  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. J. Johnson</i>   |                           | 25a. REC'D BY REGISTRAR <i>SEP 29 '61</i> DATE   |                                  |
| ADDRESS <i>Balto. 17, Md.</i>  |                           | 25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hume</i>   |                                  |

RECEIVED  
JAN 10 1964  
U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C. 20535



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9838

## CERTIFICATE OF DEATH

09827

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b><br>c. LENGTH OF STAY IN 1b <b>1 day</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Anne Arundel General Hospital</b>                          |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>e. STATE <b>Maryland</b><br>f. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL - Harwood</b><br>d. STREET ADDRESS<br>e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br><b>(Frank) John Francis PEDDICORD</b>  |  | 4. DATE OF DEATH<br>Month <b>Sept.</b> Day <b>13</b> Year <b>19 61</b>  |  |
| 5. SEX <b>Male</b><br>6. COLOR OR RACE <b>White</b><br>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 8. DATE OF BIRTH <b>Feb. 21, 1889</b><br>9. AGE (In years last birthday) <b>72</b> yrs.<br>IF UNDER 1 YEAR Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b><br>10b. KIND OF BUSINESS OR INDUSTRY <b>Tabacco</b>   |  | 11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b><br>12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>   |  |
| 13. FATHER'S NAME <b>Michael T. Peddicord</b>   |  | 14. MOTHER'S MAIDEN NAME <b>Mary Etta</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b><br>(If yes, give year or dates of service)  |  | 16. SOCIAL SECURITY NO. <b>218 36 1738</b>  |  |
| 17. INFORMANT Address <b>Mrs. Lydia M. Peddicord - Wife - same as # 2</b>   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma stomach</b><br>151X DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <b>metastases to liver and bone</b><br>(a), stating the underlying cause last. DUE TO (c) <b>Widow</b> |  | INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour e.m. p.m. <b>19</b>  |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work et work   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (the undersigned) attended the deceased from <b>July</b> , 19 <b>60</b> , to <b>Sept. 13</b> , 19 <b>61</b> , that (I) <b>(X)</b> last saw the deceased alive on <b>Sept 12</b> , 19 <b>61</b> , and that death occurred at <b>5:40 A.M.</b> , from the causes and on the date stated above.                           |  |   |  |
| 22a. SIGNATURE <b>Emily H. Wilson</b><br>22c. PHYSICIAN'S NAME (Type) <b>Dr. Emily H. Wilson</b>  |  | 22b. DATE SIGNED <b>9/13/61</b><br>ATTENDING MED. STAFF<br>PHYS. <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYS. <input type="checkbox"/><br>22d. ADDRESS <b>Lothian, Maryland</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |  | 23b. DATE THEREOF <b>Sept. 15, 61</b>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY <b>Mt Zion Methodist Cemetery</b>  |  | 23d. LOCATION (City, town or county) (State) <b>Mt Zion, Md.</b>  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Hopping Funeral Home</b>  |  | 25a. REC'D BY REGISTRAR <b>SEP 18 '61</b><br>25b. REGISTRAR'S SIGNATURE <b>Charles S. Kneass</b>  |  |

(M)

(I)

Burial

Sept. 15, 01

St. Zion Methodist Cemetery

St. Zion, Md.

Hopping Funeral Home

Annapolis, Md.

(John Francis)

Retired Farmer

Michael T. Reddick

Mary Etta

218 36 1738

no

Mrs. M. Reddick - Wife - same as 2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If the physician is not retained by the hospital or attending physician, the law requires that the death certificate be executed within 24 hours after death. If the physician is not retained by the hospital or attending physician, the law requires that the death certificate be executed within 24 hours after death.

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |                                  |   |   |  |   |   |   |   |  |  |  |  |  |
|---|--|----------------------------------|---|---|--|---|---|---|---|--|--|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |                                  |   |   |  |   |   |   |   |  |  |  |  |  |
| CERTIFICATE OF DEATH  |  |                                  |   |   |  |   |   |   |   |  |  |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>9833</u> <u>Anne Arundel</u><br><u>Glen Burnie, Maryland</u><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>Glen Burnie, Maryland</u><br>c. LENGTH OF STAY IN 1b<br><u>5 1/2 mos.</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><u>405 Glenwood Ave. Glen Burnie, M.D.</u>  |  |                                  |   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>a. STATE <u>Md.</u> b. COUNTY <u>Anne Arundel</u><br><u>405 Glenwood Ave. Glen Burnie, Md.</u><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>Glen Burnie, Maryland</u><br>d. STREET ADDRESS<br><u>405 Glenwood Ave.</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |   |   |   |  |  |  |  |  |
| 3. NAME OF DECEASED<br>(Type or print) <u>Frederick E. Polk</u>   |  |                                  |   |   | 4. DATE OF DEATH<br>Month <u>Sept.</u> Day <u>22</u> Year <u>19 61</u>   |   |   |   |   |  |  |  |  |  |
| 5. SEX<br><u>Male</u>   |  | 6. COLOR OR RACE<br><u>White</u> |   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>May 4, 1893</u>  |   | 9. AGE (In years last birthday) yrs. <u>68</u><br>IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u> |   |  |  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Glass blower</u>  |  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Glass</u>   |   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><u>Baltimore, Maryland</u> |   |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u> |  |  |  |  |  |
| 13. FATHER'S NAME<br><u>Conrad Polk</u>   |  |                                  |   |   | 14. MOTHER'S MAIDEN NAME<br><u>Clara Michael</u>   |   |   |   |   |  |  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>   |  |                                  |   |   | 16. SOCIAL SECURITY NO.<br><u>212-07-0899</u>  |   |   |   |   | 17. INFORMANT<br>Address<br><u>Mr. Ernest L. Polk (son)</u><br><u>405 Glenwood Ave. Glen Burnie, Md.</u> |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Advanced Parkinson's disease</u><br><u>350 X</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u><br>DUE TO (c) <u>Diabetes mellitus</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>  </u><br>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                  |   |   |  |   |   |   |   |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                                  |   |   | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)<br><u>  </u>   |   |   |   |   |  |  |  |  |  |
| 20c. TIME OF INJURY<br>Hour <u>  </u> a.m. <u>  </u> p.m. <u>  </u><br>Month, Day, Year<br><u>19</u>  |  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u>  </u>  |   | 20f. (City or town)<br><u>  </u> (County)<br><u>  </u> (State)<br><u>  </u> |   |   |  |  |  |  |  |
| 21. I certify that (I) <u>  </u> attended the deceased from <u>158</u> to <u>Sept. 22, 1961</u> that (I) <u>  </u> saw the deceased alive on <u>Sept. 21, 1961</u> and that death occurred <u>9:30 A.M.</u> from the causes and on the date stated above.   |  |                                  |   |   |  |   |   |   |   |  |  |  |  |  |
| 22a. SIGNATURE<br><u>R. V. Rangle, M.D.</u>   |  |                                  |   |   | 22b. DATE SIGNED<br><u>9-22-61</u>   |   |   |   |   |  |  |  |  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>R. V. Rangle, M.D.</u>   |  |                                  |   |   | 22d. ADDRESS<br><u>2938 St. Paul St. Balto. 18, Md.</u>  |   |   |   |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |  |                                  | 23b. DATE THEREOF<br><u>9/25/61</u>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Loudon Park Cem</u>   |   |   | 23d. LOCATION (City, town or county)<br><u>Balto. Md.</u> (State)<br><u>  </u>  |   |  |  |  |  |  |
| 24 FUNERAL DIRECTOR'S SIGNATURE<br><u>Howard H. Hubbard</u>   |  |                                  |   |   | 25a. REC'D BY REGISTRAR<br><u>SEP 26 '61</u>   |   |   |   |   | 25b. REGISTRAR'S SIGNATURE<br><u>C. L. H. H.</u>   |  |  |  |  |

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MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

(M)

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

|                                  |  |                                 |  |                                 |  |                                   |  |
|----------------------------------|--|---------------------------------|--|---------------------------------|--|-----------------------------------|--|
| 1. Name of Deceased              |  | 2. Sex                          |  | 3. Age                          |  | 4. Date of Death                  |  |
| 5. Place of Birth                |  | 6. Usual Residence              |  | 7. Cause of Death               |  | 8. Manner of Death                |  |
| 9. Signature of Medical Examiner |  | 10. Signature of Coroner        |  | 11. Signature of Registrar      |  | 12. Signature of Burial Officer   |  |
| 13. Signature of Physician       |  | 14. Signature of Nurse          |  | 15. Signature of Undertaker     |  | 16. Signature of Cemetery Officer |  |
| 17. Signature of Funeral Home    |  | 18. Signature of Burial Society |  | 19. Signature of Burial Society |  | 20. Signature of Burial Society   |  |
| 21. Signature of Burial Society  |  | 22. Signature of Burial Society |  | 23. Signature of Burial Society |  | 24. Signature of Burial Society   |  |
| 25. Signature of Burial Society  |  | 26. Signature of Burial Society |  | 27. Signature of Burial Society |  | 28. Signature of Burial Society   |  |
| 29. Signature of Burial Society  |  | 30. Signature of Burial Society |  | 31. Signature of Burial Society |  | 32. Signature of Burial Society   |  |
| 33. Signature of Burial Society  |  | 34. Signature of Burial Society |  | 35. Signature of Burial Society |  | 36. Signature of Burial Society   |  |
| 37. Signature of Burial Society  |  | 38. Signature of Burial Society |  | 39. Signature of Burial Society |  | 40. Signature of Burial Society   |  |
| 41. Signature of Burial Society  |  | 42. Signature of Burial Society |  | 43. Signature of Burial Society |  | 44. Signature of Burial Society   |  |
| 45. Signature of Burial Society  |  | 46. Signature of Burial Society |  | 47. Signature of Burial Society |  | 48. Signature of Burial Society   |  |
| 49. Signature of Burial Society  |  | 50. Signature of Burial Society |  | 51. Signature of Burial Society |  | 52. Signature of Burial Society   |  |
| 53. Signature of Burial Society  |  | 54. Signature of Burial Society |  | 55. Signature of Burial Society |  | 56. Signature of Burial Society   |  |
| 57. Signature of Burial Society  |  | 58. Signature of Burial Society |  | 59. Signature of Burial Society |  | 60. Signature of Burial Society   |  |
| 61. Signature of Burial Society  |  | 62. Signature of Burial Society |  | 63. Signature of Burial Society |  | 64. Signature of Burial Society   |  |
| 65. Signature of Burial Society  |  | 66. Signature of Burial Society |  | 67. Signature of Burial Society |  | 68. Signature of Burial Society   |  |
| 69. Signature of Burial Society  |  | 70. Signature of Burial Society |  | 71. Signature of Burial Society |  | 72. Signature of Burial Society   |  |
| 73. Signature of Burial Society  |  | 74. Signature of Burial Society |  | 75. Signature of Burial Society |  | 76. Signature of Burial Society   |  |
| 77. Signature of Burial Society  |  | 78. Signature of Burial Society |  | 79. Signature of Burial Society |  | 80. Signature of Burial Society   |  |
| 81. Signature of Burial Society  |  | 82. Signature of Burial Society |  | 83. Signature of Burial Society |  | 84. Signature of Burial Society   |  |
| 85. Signature of Burial Society  |  | 86. Signature of Burial Society |  | 87. Signature of Burial Society |  | 88. Signature of Burial Society   |  |
| 89. Signature of Burial Society  |  | 90. Signature of Burial Society |  | 91. Signature of Burial Society |  | 92. Signature of Burial Society   |  |
| 93. Signature of Burial Society  |  | 94. Signature of Burial Society |  | 95. Signature of Burial Society |  | 96. Signature of Burial Society   |  |
| 97. Signature of Burial Society  |  | 98. Signature of Burial Society |  | 99. Signature of Burial Society |  | 100. Signature of Burial Society  |  |



## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |   |  |  |
|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <i>Anne Arundel</i> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i>          |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Mayo</i>  |   | c. LENGTH OF STAY IN 1b <i>34 years</i>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION  |   | d. STREET ADDRESS <i>Edgewater</i>   |  |
| 3. NAME OF DECEASED (Type or print) <i>Alice</i> First <i>Estell</i> Middle <i>Quade</i> Last   |   | 4. DATE OF DEATH <i>Sept. 7</i> 1961   |  |
| 5. SEX <i>f.</i>  | 6. COLOR OR RACE <i>W.</i>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>10-15-1878</i>                                 |
| 9. AGE (In years last birthday) <i>82</i> yrs.  |   | IF UNDER 1 YEAR  | IF UNDER 24 HRS.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>   |   | 10b. KIND OF BUSINESS OR INDUSTRY  | 11. BIRTHPLACE (State or foreign country) <i>Shadyside, Md.</i>    |
| 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>  |   | 13. FATHER'S NAME <i>Thomas Crutchley</i>  |  |
| 14. MOTHER'S MAIDEN NAME <i>Lucretia Young</i>  |   | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)  |  |
| 16. SOCIAL SECURITY NO.   |   | 17. INFORMANT <i>Mrs. Grace Stallings</i> Address <i>Mayo, Md.</i>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>metastatic carcinoma of liver</i><br>DUE TO <i>159X</i><br>Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) <i>Gastrointestinal cancer and</i><br>DUE TO <i>Arteriosclerotic cardiovascular disease</i><br>(c) <i>5 years</i> |   | INTERVAL BETWEEN ONSET AND DEATH<br><i>2 months</i><br><i>6 months</i><br><i>5 years</i>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |   |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m. <i>19</i>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                               |
| 21. I certify that I attended the deceased from <i>Dec. 15, 1957</i> , to <i>Sept. 7, 1961</i> , that I last saw the deceased alive on <i>Sept. 7, 1961</i> , and that death occurred at <i>4:15 AM</i> , from the causes and on the date stated above.   |   |  |  |
| ACTUAL SIGNATURE <i>Sylvia M. Linn</i> M.D.   |   | ADDRESS (Street, city or town, state) <i>Rt. 1 Box 277 - M Edgewater, Md.</i>  |  |
| DATE SIGNED <i>9/7/61</i>   |   |  |  |
| PHYSICIAN'S NAME (Type) <i>Sylvia M. Linn</i>   |   |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>   | 22b. DATE THEREOF <i>9-10-61</i>  | 22c. NAME OF CEMETERY OR CREMATORY <i>CEDAR BLUFF</i>  | 22d. LOCATION (City, town, or county) (State) <i>ANNAPOLIS MD.</i> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor &amp; Sons</i>   |   | ADDRESS <i>Annapolis, Md.</i>  |  |
| 24a. REC'D BY REGISTRAR DATE <i>SEP 8 '61</i>   |   | 24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |                               |  |  |  |   |  |   |  |  |  |
|---|--|-------------------------------|--|--|--|---|--|---|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |                               |  |  |  |   |  |   |  |  |  |
| 9842 Item 14 Film G-97 10/16/61 iwk 09831   |  |                               |  |  |  |   |  |   |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY<br>ANNE ARUNDEL<br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>ANNAPOLIS<br>c. LENGTH OF STAY IN 1b<br>1 HOUR 5 MIN.<br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br>U.S. NAVAL HOSPITAL, ANNAPOLIS, MARYLAND |  |                               |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE<br>MARYLAND<br>b. COUNTY<br>ANNE ARUNDEL<br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>ANNAPOLIS<br>d. STREET ADDRESS<br>/ |  |   |  |  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br>Kathleen Marie ROBIDOUX  |  |                               |  |  |  | 4. DATE OF DEATH<br>Month Day Year<br>SEPTEMBER 20 19 61  |  |   |  |  |  |
| 5. SEX<br>FEMALE  |  | 6. COLOR OR RACE<br>CAUCASIAN |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br>20 SEPTEMBER 1961   |  | 9. AGE (In years last birthday)<br>1 yrs.                                     |  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.<br>1 5 |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |  |                               |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  |   |  | 11. BIRTHPLACE (County & State, or foreign country)<br>ANNE ARUNDEL, MARYLAND |  | 12. CITIZEN OF WHAT COUNTRY?<br>UNITED STATES        |  |
| 13. FATHER'S NAME<br>Normand O'Neill ROBIDOUX   |  |                               |  |  |  | 14. MOTHER'S MAIDEN NAME<br>Lucy Christine ROBIDOUX Jane Mary Bell  |  |   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br>NO   |  |                               |  | 16. SOCIAL SECURITY NO.<br>None  |  | 17. INFORMATION<br>Normand ROBIDOUX 231 Fig Road, Annapolis, Md.  |  |   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause pertaining to (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br>762.5 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>(c)<br>Primary Atelectasis<br>Pneumonia.                  |  |                               |  |  |  |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br>1 hr             |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |                               |  |  |  |   |  |   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                               |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |   |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m.<br>p.m.<br>19  |  |                               |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town)<br>--   |  | 20g. (County)<br>--                                  |  |
| 21. I certify that (I) (this hospital) attended the deceased from 20 Sept. 1961, to 20 Sept. 1961 that (I) (we) last saw the deceased alive on 20 Sept. 1961, and that death occurred at 1156A M, from the causes and on the date stated above.   |  |                               |  |  |  |   |  |   |  |  |  |
| 22a. SIGNATURE<br>Henry D. Knox   |  |                               |  |  |  | M.D.<br>ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>   |  | 22b. DATE SIGNED<br>20 Sept 61  |  |  |  |
| 22c. PHYSICIAN'S NAME (Type)<br>Henry D. KNOX LT MC USN   |  |                               |  |  |  | 22d. ADDRESS<br>U.S. NAVAL HOSPITAL, ANNAPOLIS, MD.   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE THEREOF<br>8/25/61  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>U.S.N. ACADEMY   |  |   |  | 23d. LOCATION (City, town or county) (State)<br>ANNAPOLIS MD.                 |  |  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br>John M. G. Tor...   |  |                               |  |  |  | ADDRESS<br>Chincipolis, Md.   |  | 25a. REC'D BY REGISTRAR<br>DATE SEP 25 '61                                    |  | 25b. REGISTRAR'S SIGNATURE<br>Arthur S. Kraus        |  |

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| 1. PLACE OF DEATH<br>a. COUNTY <u>GA Co</u>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MD</u>   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Harmon 5 yrs</u>  |  | b. COUNTY <u>GA Co</u>  |  |
| c. LENGTH OF STAY IN 1b   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Harmon GA Co Md</u> |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Shipley Ave</u>   |  | d. STREET ADDRESS <u>1 Rural</u>  |  |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |
| 3. NAME OF DECEASED (Type or print) <u>Maud</u> First <u>S</u> Middle <u>Rudolph</u> Last   |  | 4. DATE OF DEATH <u>Sept</u> Month <u>11</u> Day <u>1961</u> Year   |  |
| 5. SEX <u>Female</u>  |  | 6. COLOR OR RACE <u>White</u>   |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 8. DATE OF BIRTH <u>Nov 20 - 1877</u>   |  |
| 9. AGE (In years last birthday) <u>83</u> yrs.  |  | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife Retired</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore Md</u>   |  |
| 11. BIRTHPLACE (State or foreign country)   |  | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>   |  |
| 13. FATHER'S NAME <u>Clarence A. Pindell</u>  |  | 14. MOTHER'S MAIDEN NAME <u>Johnson</u>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>none</u>   |  | 16. SOCIAL SECURITY NO. <u>none</u>   |  |
| INFORMANT <u>Robert Rudolph</u> Address <u>Shipley Ave Harmon Md</u>  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>422.1 CONGESTIVE HEART FAILURE</u><br>DUE TO (b) <u>ARTERIO-SCLEROTIC CARDIO-VASCULAR DISEASE</u><br>DUE TO (c) <u>2 YRS</u>  |  | INTERVAL BETWEEN ONSET AND DEATH <u>2 YRS</u>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                  |  |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>   |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>        |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <u>Aug. 1956</u> to <u>9-11-1961</u> , that I last saw the deceased alive on <u>9-9-1961</u> , and that death occurred at <u>7:30 P</u> M, from the causes and on the date stated above<br>ADDRESS (Street, city or town, state) <u>201 BrA Blvd</u> DATE SIGNED <u>9-12-61</u><br>ACTUAL SIGNATURE <u>Leon C. Perry</u> M.D. <u>GLEN BURNIE, MD.</u><br>PHYSICIAN'S NAME (Type) <u>LEON C. PERRY, M.D.</u> |  |   |  |
| 22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>  |  | 22b. DATE THEREOF <u>Sept 14-61</u>   |  |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore City Md</u>   |  | 22d. LOCATION (City, town, or county) (State)   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard A. Frank</u> ADDRESS <u>Baltimore Md</u>  |  | 24a. REC'D BY REGISTRAR DATE <u>SEP 12 '61</u>  |  |
| 24b. REGISTRAR'S SIGNATURE  |  |   |  |

VS A15 (4)  
15M 9/58





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 3 and 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |  |  |  |  |  |  |
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| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |  |  |  |  |  |  |  |  |
| 9844 CERTIFICATE OF DEATH 05833  |  |  |  |  |  |  |  |  |  |
| Item 23 F11m 0294 9/11/61  |  |  |  |  |  |  |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>ANNE ARUNDEL</b> <b>MARYLAND</b>   |  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MD.</b> b. COUNTY <b>ANNE ARUNDEL</b> |  |  |  |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>PASEDENA</b>   |  |  |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PASEDENA</b>   |  |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>4 CARNENE DRIVE</b>  |  |  |  |  | d. STREET ADDRESS <b>14 CARNENE DRIVE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>              |  |  |  |  |
| 3. NAME OF DECEASED (Type or print) <b>IDA</b>   |  |  |  |  | 4. DATE OF DEATH <b>Sept. 2 1961</b>   |  |  |  |  |
| 5. SEX <b>F</b>  |  |  |  |  | 6. COLOR OR RACE <b>W</b>  |  |  |  |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |  |  |  | 8. DATE OF BIRTH <b>MARCH 10, 1870</b>   |  |  |  |  |
| 9. AGE (In years last birthday) <b>91</b> yrs.   |  |  |  |  | 10. IF UNDER 1 YEAR Months Days  |  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>  |  |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>1</b>   |  |  |  |  |
| 11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>  |  |  |  |  | 12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>  |  |  |  |  |
| 13. FATHER'S NAME <b>JOHN T. MOON</b>  |  |  |  |  | 14. MOTHER'S MAIDEN NAME <b>EMMA STAHL</b>   |  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>  |  |  |  |  | 16. SOCIAL SECURITY NO. <b>NONE</b>  |  |  |  |  |
| 17. INFORMANT <b>MRS. ADELENE S. GANTER</b>  |  |  |  |  | Address <b>4 CARNENE DRIVE PASADENA, MD</b>  |  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE</b><br><b>331X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) }<br>(a), stating the underlying cause last. (c) } DUE TO<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)<br>INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> |  |  |  |  |  |  |  |  |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |  |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  |  |  |  |  |  |  |
| 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |  |  |  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>  |  |  |  |  |  |  |  |  |  |
| 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  |  |  |  |  |  |  |  |  |
| 20f. (City or town) (County) (State)   |  |  |  |  |  |  |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Aug 1</b> to <b>Sept 2</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>Sept 1</b> , 19 <b>61</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.   |  |  |  |  |  |  |  |  |  |
| 22a. SIGNATURE <b>Benj S Abeshouse</b> M.D.  |  |  |  |  |  |  |  |  |  |
| 22b. DATE SIGNED <b>9/3/61</b>   |  |  |  |  |  |  |  |  |  |
| 22c. PHYSICIAN'S NAME (Type) <b>BENJ. S. ABESHOUSE MD</b>  |  |  |  |  |  |  |  |  |  |
| 22d. ADDRESS <b>100 W MONUMENT ST. BALTIMORE 1</b>   |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>  |  |  |  |  |  |  |  |  |  |
| 23b. DATE THEREOF <b>9-5-61</b>  |  |  |  |  |  |  |  |  |  |
| 23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE Cemetery</b>   |  |  |  |  |  |  |  |  |  |
| 23d. LOCATION (City, town or county) (State) <b>BALTIMORE, MARYLAND</b>  |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <b>WM. COOK INC. 1217 ST. PAUL ST.</b> ADDRESS  |  |  |  |  |  |  |  |  |  |
| 25a. REC'D BY REGISTRAR <b>SEP 6 '61</b> DATE  |  |  |  |  |  |  |  |  |  |
| 25b. REGISTRAR'S SIGNATURE <b>C. L. S. Kline</b>   |  |  |  |  |  |  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

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|--|---|---|---|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>  |   | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; if not, where admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>         |   |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>Annapolis</u>   |   | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>Linthicum</u>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><u>Dead on arrival</u><br><u>Anne Arundel General Hospital</u>   |   | d. STREET ADDRESS<br><u>100 West Twin Oaks Road</u>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Charles</u> Middle <u>F</u> Last <u>SCHNOPPS</u>   |   | 4. DATE OF DEATH<br>Month <u>Sept.</u> Day <u>27</u> Year <u>1961</u>   |   |
| 5. SEX<br><u>Male</u>  | 6. COLOR OR RACE<br><u>White</u>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>July 2, 1919</u>                               |
| 9. AGE (in years last birthday)<br><u>42</u> yrs.  |   | 10. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Chauffeur</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Trucking</u>  |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><u>Massachusetts North Adams</u>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.</u>   |   |
| 13. FATHER'S NAME<br><u>Frederick J Schnapps</u>   |   | 14. MOTHER'S MAIDEN NAME<br><u>Clara Blount</u>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>  |   | 16. SOCIAL SECURITY NO. <u>015-16-5180</u>  |   |
| 17. INFORMANT<br><u>Mrs Florence Schnapps</u>  |   | Address<br><u>  </u>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u><br><u>420.0</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerotic Heart Disease</u><br>(c) <u>  </u> DUE TO<br>(e), stating the underlying cause last.<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u><br>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>5 minutes</u><br><u>2 years</u>  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. <u>  </u> p.m. <u>19</u>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)                                  |
| 21. I certify that (I) <u>this doctor</u> attended the deceased from <u>2/23, 1961</u> to <u>9/27, 1961</u> , that (I) <u>xx</u> last saw the deceased alive on <u>9/18, 1961</u> , and that death occurred at <u>4:50 A.M.</u> from the causes and on the date stated above.  |   |   |   |
| 22a. SIGNATURE<br><u>Richard I. Hochman</u>  |   | 22b. DATE SIGNED<br><u>9/27/61</u>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><u>Richard I. Hochman</u>  |   | 22d. ADDRESS<br><u>100 Cathedral St., Annapolis, Md.</u>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   | 23b. DATE THEREOF<br><u>Sept 30 - 61</u>  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Northview Memorial Mass</u>  | 23d. LOCATION (City, town, or county) (State)<br><u>No Adams Mass</u> |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><u>Bernard G. Fink</u>   |   | 25a. REC'D BY REGISTRAR<br><u>Glen Burnum Md</u>  |   |
| 25b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Kraus</u>   |   | DATE<br><u>SEP 28 '61</u>   |   |

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

9846

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|   |   |   |  |   |   |   |  |
|---|---|---|--|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>  |   |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>e. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> |   |   |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis</b>  |   | c. LENGTH OF STAY IN lb<br><b>2 days</b>  |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>RURAL - Severna Park</b>                                 |   |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>Anne Arundel General Hospital</b>  |   |   |  | d. STREET ADDRESS<br><b>Rt-2, Box-391B</b>  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>George SCOTT</b>   |   |   |  | 4. DATE OF DEATH<br>Month <b>September</b> Day <b>28</b> Year <b>1961</b>   |   |   |  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>Negro</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>April 8, 1918</b> | 9. AGE (In years last birthday)<br><b>43 yrs.</b>   | IF UNDER 1 YEAR<br>Months <b></b> Days <b></b> Hours <b></b> Min. <b></b> | IF UNDER 24 HRS.<br>Hours <b></b> Min. <b></b>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Laborer</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b></b>  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Maryland</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |  |
| 13. FATHER'S NAME<br><b>George A. Scott Sr.</b>   |   |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Mary F. Young</b>  |   |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b></b>  |   | 16. SOCIAL SECURITY NO.<br><b></b>  |  | 17. INFORMANT<br><b>Helen Ringgold Murphy St. Anne</b>  |   |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>493X</b> DUE TO <b>neumonia</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Severe infection</b><br>(c) <b></b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)<br><b>Diabetes Mellitus</b> |   |   |  |   |   |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |   |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour e.m.<br>p.m. <b>19</b>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town)                      | (County)  | (State)   | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21. I certify that (I) <b>(no person)</b> attended the deceased from <b>Sept. 26, 1961</b> to <b>Sept. 28, 1961</b> , that (I) <b>(we)</b> last saw the deceased alive on <b>Sept. 28, 1961</b> , and that death occurred at <b>11:30 A.M.</b> from the causes and on the date stated above.  |   |   |  |   |   |   |  |
| 22a. SIGNATURE<br><b>Gerard Church</b>  |   |   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                 |   | 22b. DATE SIGNED  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>GERARD CHURCH</b>  |   |   |  | 22d. ADDRESS<br><b>121 Cathedral St., Annapolis, Md.</b>  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE THEREOF<br><b>10-4-1961</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Carpenter Hill</b>   |  | 23d. LOCATION (City, town or county) (State)<br><b>Round Bay Md.</b>  |   |   |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>William Reese # Anna Md.</b>   |   |   |  | 25a. REC'D BY REGISTRAR<br><b>OCT 2 1961</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Evans</b>  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and to any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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| MARYLAND STATE DEPARTMENT OF HEALTH  |  |   |  |  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|--|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |   |  |  |  |   |  |  |  |   |  |
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| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>   |  |   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>e. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> |  |  |  |   |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis</b>   |  |   |  | c. LENGTH OF STAY IN 1b  |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>10 Annapolis</b>   |  |  |  | d. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>Dead on Arrival</b><br><b>Anne Arundel General Hospital</b>   |  |   |  |  |  | d. STREET ADDRESS<br><b>2 Maryland Ave.</b>   |  |  |  |   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>Mary</b> Middle <b>J</b> Last <b>SEITZINGER</b>   |  |   |  |  |  | 4. DATE OF DEATH<br>Month <b>Sept.</b> Day <b>20</b> Year <b>19 61</b>  |  |  |  |   |  |
| 5. SEX<br><b>Female</b>  |  | 6. COLOR OR RACE<br><b>White</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>April 20, 1876</b>   |  | 9. AGE (In years last birthday)<br><b>85 yrs.</b>    |  | IF UNDER 1 YEAR<br>Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/> |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>HOME</b>   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>England</b>   |  |  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |  |
| 13. FATHER'S NAME<br><b>JOHN PHILIPS MORRIS</b>  |  |   |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>UNKNOWN</b>  |  |  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give year or dates of service)<br><b>NO</b>   |  |   |  | 16. SOCIAL SECURITY NO.<br><b>—</b>  |  | 17. INFORMANT<br><b>ARTHUR E. SEITZINGER MD.</b> Address <b>MARY</b>  |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4 20.0 Congestive Heart Failure</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <b>Arteriosclerotic heart disease</b><br>(c) <b>20 years</b><br>DUE TO<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)<br><b>INTERVAL BETWEEN ONSET AND DEATH</b><br><b>28 days</b> |  |   |  |  |  |   |  |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |   |  |
| 20c. TIME OF INJURY<br>Hour e.m. <b>19</b><br>p.m.   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town)   |  | (County)   |  | (State)   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>8/23</b> , 1961, to <b>9/19</b> , 1961, that (I) <del>(we)</del> last saw the deceased alive on <b>9/13</b> , 1961, and that death occurred at <b>M</b> , from the causes and on the date stated above.   |  |   |  |  |  |   |  |  |  |   |  |
| 22a. SIGNATURE<br><b>Richard I. Hochman</b> M.D.   |  |   |  |  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                 |  | 22b. DATE SIGNED<br><b>9/20/61</b>                   |  |   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Richard I. Hochman</b>  |  |   |  |  |  | 22d. ADDRESS<br><b>121 Cathedral St., Annapolis, Md.</b>  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |  | 23b. DATE THEREOF<br><b>9-23-61</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MOUNT HOPE CEM.</b>   |  | 23d. LOCATION (City, town or county)<br><b>CHICAGO ILL</b>  |  | (State)  |  |   |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>John M. Taylor</b> <b>Sons Annapolis Md</b>   |  |   |  |  |  | 25a. REC'D BY REGISTRAR<br><b>SEP 25 '61</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b> |  |   |  |

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*[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "HISTORICAL" and "RECORD" are faintly visible.]*

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film G295 9/15/61 iwk

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CERTIFICATE OF DEATH

Reg. Dist. No. 17

98837

|   |                               |   |   |
|---|-------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Millersville</b><br>c. LENGTH OF STAY IN 1b<br>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Knollwood Manor</b>  |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Anne Arundel</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Seyern</b><br>d. STREET ADDRESS <b>Box 178, Park Station Rd</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED (Type or print) <b>EZRA C SHENTON</b>   |                               | 4. DATE OF DEATH <b>September 4, 1961</b>   |   |
| 5. SEX <b>Male</b>  | 6. COLOR OR RACE <b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH <b>Aug. 2, 1882 1883</b> |
| 9. AGE (In years last birthday) <b>78</b> yrs.  |                               | IF UNDER 1 YEAR<br>Months <b>7</b> Days <b>18</b> Hours <b>15</b> Min.  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARPENTER</b>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY <b>MARYLAND</b>   |   |
| 11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>   |                               | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |   |
| 13. FATHER'S NAME <b>Raymond Shenton</b>  |                               | 14. MOTHER'S MAIDEN NAME <b>Cora Gillingham</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>  |                               | 16. SOCIAL SECURITY NO. <b>216-07-6549</b>  |   |
| 17. INFORMANT <b>Mrs Verona Shenton- Wife- same as # 2</b>  |                               | Address   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>491X</b> <b>broncho pneumonia</b><br>DUE TO (b) <b>2 days</b><br>DUE TO (c) <b>2 days</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebro vascular disease</b>          |                               |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>  |                               | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>  |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                               | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I attended the deceased from <b>July</b> , 19 <b>61</b> , to <b>September</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>Aug 31st</b> , 19 <b>61</b> , and that death occurred at <b>10.10a</b> M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>121 Cathedrae Street, Annapolis, Md.</b><br>DATE SIGNED <b>Gerard Church</b> |                               |   |   |
| ACTUAL SIGNATURE <b>Gerard Church</b>   |                               | M.D.  |   |
| PHYSICIAN'S NAME (Type) <b>Gerard Church MD</b>   |                               | <b>121 Cathedrae Street, Annapolis, Md.</b>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |                               | 22b. DATE THEREOF <b>Sept. 7, 1961</b>  |   |
| 22c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Cemetery</b>   |                               | 22d. LOCATION (City, town, or county) (State) <b>Glen Burnie, Md.</b>   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping and Kirkley</b>   |                               | ADDRESS <b>Glen Burnie, Md.</b>   |   |
| 24a. REGISTRY REGISTRAR <b>SEP 11 1961</b>  |                               | DATE <b>DATE</b>  |   |
| 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>   |                               |   |   |

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54. *Interim note*

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |   |   |   |  |                                    |   |  |                              |  |                       |  |  |  |
|--|--|---|---|---|--|------------------------------------|---|--|------------------------------|--|-----------------------|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |   |   |   |  |                                    |   |  |                              |  |                       |  |  |  |
| CERTIFICATE OF DEATH   |  |   |   |   |  |                                    |   |  |                              |  |                       |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>   |  |   |   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> |                                    |   |  |                              |  |                       |  |  |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Crownsville</b>   |  |   | c. LENGTH OF STAY IN 1b<br><b>5 yrs. 13 da.</b>   |   | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore</b>   |                                    |   |  |                              |  |                       |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>Crownsville State Hospital</b>  |  |   |   |   | d. STREET ADDRESS<br><b>2427 Etting Street</b>   |                                    |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                              |  |                       |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>Joseph Henry Sisco</b>  |  |   |   |   | 4. DATE OF DEATH<br>Month Day Year<br><b>9 6 1961</b>  |                                    |   |  |                              |  |                       |  |  |  |
| 5. SEX<br><b>Male</b>  |  | 6. COLOR OR RACE<br><b>Negro</b>                    |   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>Unknown</b> |   | 9. AGE (In years last birthday)<br><b>90?</b>  |                              |  |                       |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Unknown</b> |   | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Maryland</b>  |  |                                    | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b> |  |                              |  |                       |  |  |  |
| 13. FATHER'S NAME<br><b>Unknown</b>  |  |   |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>   |                                    |   |  |                              |  |                       |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war and dates of service)<br><b>No</b>   |  |   |   |   | 16. SOCIAL SECURITY NO.<br><b>Unknown</b>  |                                    |   |  |                              | 17. INFORMANT<br><b>Hospital Records</b><br>Address  |                       |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hypostatic pneumonia</b><br>DUE TO (b) <b>Cardia decompensation</b><br>DUE TO (c) <b>Arteriosclerotic heart disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |   |   |  |                                    |   |  |                              | INTERVAL BETWEEN ONSET AND DEATH                     |                       |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Chronic Brain Syndrome Associated with Cerebral Arteriosclerosis</b>   |  |   |   |   |  |                                    |   |  |                              |  |                       |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br>-----   |  |                                    |   |  |                              |  |                       |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m.<br>p.m.<br><b>19</b>  |  |   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                    | 20f. (City or town)<br><b>Baltimore</b>         |  | (County)<br><b>Baltimore</b> |  | (State)<br><b>Md.</b> |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>8/23</b> , 19 <b>56</b> , to <b>9/6</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>9/6</b> , 19 <b>61</b> , and that death occurred at <b>8:30</b> , from the causes and on the date stated above.  |  |   |   |   |  |                                    |   |  |                              |  |                       |  |  |  |
| 22a. SIGNATURE<br><b>L. Benedict</b>   |  |   |   |   | M.D.<br><b>L. Benedict, M. D.</b>  |                                    |   | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/><br><b>9/6/61</b> |                              | 22b. DATE SIGNED<br><b>9/6/61</b>                    |                       |  |  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>L. Benedict, M. D.</b>  |  |   |   |   | 22d. ADDRESS<br><b>Crownsville State Hospital, Crownsville, Md.</b>  |                                    |   |  |                              |  |                       |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>9/9/61</b>   |  |   | 23b. DATE THEREOF<br><b>9/9/61</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Wt Auburn</b>   |                                    |   | 23d. LOCATION (City, town or county) (State)<br><b>Baltimore</b>   |                              |  |                       |  |  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Holland Funeral Home</b>  |  |   |   |   | ADDRESS<br><b>1634 Druid Hill Ave</b>  |                                    |   | 25a. REC'D BY REGISTRAR<br><b>SEP 8 '61</b>  |                              | 25b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Hines</b> |                       |  |  |  |

(M)

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James Marshall

Marshall

Crownville

5 years 15 days

Marshall

Crownville State Hospital

237 Spring Street

Joseph

Henry

Class

Male

Marshall

Unknown

307

Married

Unknown

Marshall

U. S. A.

Unknown

Unknown

Unknown

Marshall, Harold

Psychotic pneumonia

Cardiac decompensation

Arteriosclerotic heart disease

Chronic in an unknown associated with General arteriosclerosis

61

5/6

50

8/23

8/20

8/20

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1. General, H. B.

Crownville State Hospital, Crownville, Md.

Chief, J. R. R.

8/20

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

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|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b><br>c. LENGTH OF STAY IN 1b <b>34 yrs. 10 mos. 1 da.</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Crownsville State Hospital</b> |  |  | 2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Worcester</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bishopville</b><br>d. STREET ADDRESS <b>23X-2</b><br>e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 3. NAME OF DECEASED<br>(Type or print) <b>Bessie Smack</b>  |  |  | 4. DATE OF DEATH<br>Month <b>9</b> Day <b>13</b> Year <b>1961</b>  |   |  |
| 5. SEX <b>Female</b>  |  | 6. COLOR OR RACE <b>Negro</b>                  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 8. DATE OF BIRTH <b>1899</b>  |  | 9. AGE (In years last birthday) <b>62 yrs.</b> |  | IF UNDER 1 YEAR: Months <b>9</b> Days <b>13</b> Hours <b>13</b> Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>UNKNOWN</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>   |  | 11. BIRTHPLACE (County & State, or foreign country) <b>Delaware</b>   |  |
| 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  | 13. FATHER'S NAME <b>Lemuel Waples</b>         |  | 14. MOTHER'S MAIDEN NAME <b>Martha ? Rogers</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>   |  | 16. SOCIAL SECURITY NO. <b>UNKNOWN</b>         |  | 17. INFORMANT <b>Hospital Records</b>   |  |

|   |  |                                  |
|---|--|----------------------------------|
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br>DUE TO (b) <b>Hypertensive Cardio-Vascular Disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>---</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Manic Depressive Psychosis - Manic Type</b> |  | INTERVAL BETWEEN ONSET AND DEATH |
|---|--|----------------------------------|

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|--|--|---|--|
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>---</b>   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year <b>11/12/26</b><br>Hour a.m. <b>8:20</b> p.m. <b>---</b>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>---</b>  |  | 20f. (City or town) <b>Belleville, Del.</b> (County) <b>---</b> (State) <b>---</b>                        |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>11/12/26</b> , 19 <b>61</b> , to <b>9/13</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>9/13</b> , 19 <b>61</b> , and that death occurred at <b>8:20</b> M, from the causes and on the date stated above. |  |   |  |
| 22a. SIGNATURE <b>L. Benedict, M. D.</b>   |  | 22b. DATE SIGNED <b>9/13/61</b>   |  |
| 22c. PHYSICIAN'S NAME (Type) <b>L. Benedict, M. D.</b>   |  | 22d. ADDRESS <b>Crownsville State Hospital, Crownsville, Md.</b>  |  |

|   |  |                                  |  |   |  |  |  |
|---|--|----------------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>                   |  | 23b. DATE THEREOF <b>9/16/61</b> |  | 23c. NAME OF FUNERAL HOME <b>Rogers</b>   |  | 23d. LOCATION (City, town or village, State) <b>Belleville, Del.</b> |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Reese # 108 W. Washington St.</b> |  |                                  |  | 25a. REC'D BY REGISTRAR <b>SEP 20 '61</b> |  | 25b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>                   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If the law requires that the death certificate be executed within 24 hours after death, the law requires that the death certificate be executed within 24 hours after death.

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |  |   |  |  |  |  |
|---|--|--|--|--|---|--|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |  |  |  |   |  |  |  |  |
| 9851  |  |  |  |  |   |  |  |  |  |
| 09840   |  |  |  |  |   |  |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>  |  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> |  |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis</b>  |  |  |  |  | c. LENGTH OF STAY IN 1b<br><b>40 minutes</b>  |  |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Anne Arundel General Hospital</b>  |  |  |  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Baby Boy</b>   |  |  |  |  | 4. DATE OF DEATH<br>Month <b>Sept.</b> Day <b>1</b> Year <b>19 61</b>   |  |  |  |  |
| 5. SEX<br><b>Male</b>   |  |  |  |  | 6. COLOR OR RACE<br><b>White</b>  |  |  |  |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |  |  |  | 8. DATE OF BIRTH<br><b>Sept. 1, 1961</b>  |  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>---</b>   |  |  |  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Maryland</b>  |  |  |  |  |
| 13. FATHER'S NAME<br><b>Maurice Louis SMIT</b>  |  |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Catherine "M" Carty</b>  |  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>---</b>   |  |  |  |  | 17. INFORMANT<br><b>Hospital records</b>  |  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Premature separation, Placenta</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.<br>DUE TO<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)<br>19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  |  | 22b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. p.m.<br><b>19</b>  |  |  |  |  | 22d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>                                       |  |  |  |  |
| 20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  |  |  |  | 20f. (City or town) (County) (State)  |  |  |  |  |
| 21. I certify that (I) (the deceased) attended the deceased from <b>Sept. 1, 1961</b> , to <b>Sept. 1, 1961</b> , that (I) (we) last saw the deceased alive on <b>Sept. 1, 1961</b> , and that death occurred at <b>4:30 PM</b> , from the causes and on the date stated above.   |  |  |  |  |   |  |  |  |  |
| 22e. SIGNATURE<br><b>Joseph C. Sheehan</b>  |  |  |  |  | 22b. DATE SIGNED<br><b>9/2/61</b>   |  |  |  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Joseph C. Sheehan</b>  |  |  |  |  | 22d. ADDRESS<br><b>69 Franklin St., Annapolis, Md.</b>  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  |  |  |  | 23b. DATE THEREOF<br><b>Sept 6, 1961</b>  |  |  |  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Hillcrest Cemetery</b>   |  |  |  |  | 23d. LOCATION (City, town or county) (State)<br><b>Annapolis, Maryland</b>  |  |  |  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Hopping Funeral Home</b>   |  |  |  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>SEP 8 '61</b>  |  |  |  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Haines</b>   |  |  |  |  |   |  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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| MARYLAND STATE DEPARTMENT OF HEALTH  |  |   |  |   |   |   |   |   |  |   |  |
|--|--|---|--|---|---|---|---|---|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |   |  |   |   |   |   |   |  |   |  |
| 9852   |  |   |  | CERTIFICATE OF DEATH  |   |   | 09841   |   |  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Anne Arundel</b>  |  |   |  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Baltimore</b> |   |   |   |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Crownsville</b>   |  |   |  |   | c. LENGTH OF STAY IN 1b<br><b>12 yrs.<br/>8 mos. 7 days</b>   |   |   |   |  |   |  |
| c. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>Crownsville State Hospital</b>  |  |   |  |   | d. STREET ADDRESS<br><b>1204 W. Lexington Street</b>  |   |   |   |  |   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Jeremiah</b>  |  |   |  |   | 4. DATE OF DEATH<br><b>9 20 19 61</b>   |   |   |   |  |   |  |
| 5. SEX<br><b>Male</b>  |  | 6. COLOR OR RACE<br><b>Negro</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH<br><b>1885</b>                                       |   | 9. AGE (In years last birthday)<br><b>75</b>  |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Laborer</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>-----</b>   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Maryland</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                         |   | a. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |
| 13. FATHER'S NAME<br><b>Unknown</b>  |  |   |  |   | 14. MOTHER'S MAIDEN NAME<br><b>Mary Jane Savage</b>   |   |   |   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)<br><b>No</b>  |  | 16. SOCIAL SECURITY NO.<br><b>Unknown</b>   |  | 17. INFORMANT<br><b>Hospital Records</b>  |   |   |   |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Uremia</b><br>334X DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <b>Dehydration and Inanition</b><br>(e), stating the underlying cause last. DUE TO (c) <b>Senility &amp; Hypostatic Pneumonia</b> |  |   |  |   |   |   |   |   |  | INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>Chronic Brain Syndrome associated with Generalized &amp; Cerebral Arterio-</b>  |  |   |  |   |   |   |   |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>sclerosis</b>  |  |   |   |   |   |   |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour <b>-----</b><br>p.m. <b>19</b>   |  | 20d. INJURY OCCURRED<br>While <input checked="" type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>-----</b>  |   | 20f. (City or town)<br><b>-----</b>                                   |   | (County)<br><b>-----</b>  |  |   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>8/1 1947</b> , to <b>9/20 1961</b> , that (I) (we) last saw the deceased alive on <b>9/20 1961</b> , and that death occurred at <b>5:15 P.M.</b> from the causes and on the date stated above.  |  |   |  |   |   |   |   |   |  | 22b. DATE SIGNED<br><b>9/20/61</b>  |  |
| 22a. SIGNATURE<br><b>Lionel McHenry Mapp, M. D.</b>  |  |   |  |   | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                       |   | 22c. ADDRESS<br><b>Crownsville State Hospital, Maryland</b> |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE THEREOF<br><b>9/26/61</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Andrew's</b>   |   | 23d. LOCATION (City, town or county) (State)<br><b>Baltimore City</b> |   |   |  |   |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>F. Halstead</b>   |  | ADDRESS<br><b>9182 Druid Hill Ave.</b>  |  | 25a. REC'D BY REGISTRAR<br><b>SEP 25 '61</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Hanna</b>                  |   |   |  |   |  |

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 9853 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

09842

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <b>Anne Arundel</b> <span style="float: right;">MARYLAND</span><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis</b><br>c. LENGTH OF STAY IN 1b<br><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>DOA Anne Arundel General Hospital</b>   |  |   |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>Anne Arundel</b></span><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>X RFD 2 Annapolis</b><br>d. STREET ADDRESS<br><b>St. Margarets</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| <b>3. NAME OF DECEASED</b> (Type or print)<br><div style="display: flex; justify-content: space-between;"> <span>First <b>LOUISE</b></span> <span>Middle <b>H</b></span> <span>Last <b>SPOERL</b></span> </div>  |  |   |  | <b>4. DATE OF DEATH</b><br><div style="display: flex; justify-content: space-between;"> <span>Month <b>September</b></span> <span>Day <b>7</b></span> <span>Year <b>19 61</b></span> </div>   |  |  |  |
| <b>5. SEX</b><br><b>Female</b>   |  | <b>6. COLOR OR RACE</b><br><b>White</b>   |  | <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br><b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |  |  |
| <b>8. DATE OF BIRTH</b><br><b>Sept 13, 1889</b>  |  | <b>9. AGE</b> (In years last birthday)<br><b>71 yrs.</b>  |  | <b>10. IF UNDER 1 YEAR</b><br>Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>  |  |  |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><b>House wife</b>  |  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><b>own home</b>   |  | <b>11. BIRTHPLACE</b> (State or foreign country)<br><b>St. Mary's County Md.</b>  |  |  |  |
| <b>12. CITIZEN OF WHAT COUNTRY?</b><br><b>USA</b>  |  |   |  |   |  |  |  |
| <b>13. FATHER'S NAME</b><br><b>Webster Hayden</b>  |  |   |  | <b>14. MOTHER'S MAIDEN NAME</b><br><b>Mary Gaugh</b>  |  |  |  |
| <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b><br>(Yes, no, or unknown)<br><b>no</b>  |  | <b>16. SOCIAL SECURITY NO.</b><br>(If yes, give war or dates of service)<br><b>no</b>   |  | <b>17. INFORMANT</b><br><b>Mrs Kathleen Lawlor- Sister- same as # 2</b>   |  |  |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br><div style="display: flex;"> <div style="flex: 1;"> <b>PART I. DEATH WAS CAUSED BY:</b><br/> <b>IMMEDIATE CAUSE (a)</b><br/> <b>434.4</b><br/>           Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br/> <b>DUPLICATE</b> </div> <div style="flex: 1;"> <b>DUPLICATE</b><br/> <b>INTERVAL BETWEEN ONSET AND DEATH</b><br/> <b>Sudden</b> </div> </div> |  |   |  |   |  |  |  |
| <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>  |  |   |  |   |  |  |  |
| <b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>   |  | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |  |  |
| <b>20c. TIME OF INJURY</b><br>Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   |  | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)<br><b>20f. (City or town)</b> (County) (State)  |  |  |  |
| <b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from:</b><br>Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>  |  |   |  |   |  |  |  |
| <b>ACTUAL SIGNATURE</b><br><b>EXAMINER'S NAME (Type)</b> <b>Elmer G. Linhardt</b>  |  | <b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/><br><b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/><br><b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> |  | <b>DATE SIGNED</b><br><b>Sept 7/61</b>  |  |  |  |
| <b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b><br><b>Burial</b>  |  | <b>22b. DATE THEREOF</b><br><b>Sept 11, 1961</b>  |  | <b>22c. NAME OF CEMETERY OR CREMATORY</b><br><b>Arlington National Cem.</b>   |  |  |  |
| <b>22d. LOCATION (City, town, or county)</b><br><b>Arlington, Va.</b>  |  |   |  |   |  |  |  |
| <b>23. FUNERAL DIRECTOR'S SIGNATURE</b><br><b>Hopping Funeral Home</b>   |  | <b>ADDRESS</b><br><b>Annapolis, Maryland</b>  |  | <b>24a. REC'D BY REGISTRAR</b><br><b>SEP 11 '61</b>   |  |  |  |
| <b>24b. REGISTRAR'S SIGNATURE</b><br><b>Arthur S. Harris</b>   |  |   |  |   |  |  |  |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your own files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9854

## CERTIFICATE OF DEATH

09843

|   |   |  |  |   |                                      |  |   |
|---|---|--|--|---|--------------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>  |   |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> |                                      |  |   |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>Annapolis</u>  |   | c. LENGTH OF STAY IN 1b<br><u>2 hrs.</u>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>RURAL - Crownsville</u>                                  |                                      |  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><u>Anne Arundel General Hospital</u>  |   |  |  | d. STREET ADDRESS<br><u>1</u>   |                                      |  |   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <u>Irvin</u> Middle <u>Carl</u> Last <u>STEPNEY</u>   |   |  |  | 4. DATE OF DEATH<br>Month <u>Sept.</u> Day <u>9</u> Year <u>19 61</u>   |                                      |  |   |
| 5. SEX<br><u>Male</u>   | 6. COLOR OR RACE<br><u>Negro</u>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>Sept. 9, 1961</u> |   | 9. AGE (In years last birthday) yrs. | IF UNDER 1 YEAR<br>Months <u>1</u> Days <u>55</u>                    | IF UNDER 24 HRS.<br>Hours <u>1</u> Min. <u>55</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |   | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><u>Maryland</u>  |                                      | 12. CITIZEN OF WHAT COUNTRY<br><u>U.S.</u>                           |   |
| 13. FATHER'S NAME<br><u>John Henry Stepney</u>  |   |  |  | 14. MOTHER'S MAIDEN NAME<br><u>Shirley Geraldine Williamson</u>   |                                      |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)   |   | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT<br><u>Hospital records</u>  |                                      | Address  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>776X</u> DUE TO <u>Premature</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |   |  |  |   |                                      | INTERVAL BETWEEN ONSET AND DEATH                                     |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |                                      |  |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. p.m.<br><u>19</u>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |                                      |  |   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Sept. 9, 1961</u> to <u>Sept. 9, 1961</u> , that (I) <u>xx</u> saw the deceased alive on <u>Sept. 9, 1961</u> , and that death occurred at <u>6:45 PM</u> from the causes and on the date stated above.  |   |  |  |   |                                      |  |   |
| 22a. SIGNATURE<br><u>R. L. Richardson</u>   |   |  |  | ATTENDING MED. STAFF<br>PHYS. <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYS. <input type="checkbox"/>              |                                      | 22b. DATE SIGNED   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><u>Dr. R. L. Richardson</u>   |   |  |  | 22d. ADDRESS<br><u>110 Clay St., Annapolis, Md.</u>   |                                      |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |   | 23b. DATE THEREOF<br><u>9-12-61</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Wilson Memorial</u>  |                                      | 23d. LOCATION (City, town or county) (State)<br><u>Gambells, Md.</u> |   |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><u>William Reese, Jr. - Annapolis, Md.</u>  |   |  |  | 25a. REC'D BY REGISTRAR<br><u>SEP 20 '61</u>  |                                      | 25b. REGISTRAR'S SIGNATURE<br><u>Charles L. Hines</u>                |   |

MEDICAL CERTIFICATION

VR A15 (4)  
15M 9/60

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

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|  |                           |  |                                   |
|--|---------------------------|--|-----------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY<br>Anne Arundel<br>MARYLAND   |                           | 2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>a. STATE<br>Maryland<br>b. COUNTY<br>Anne Arundel |                                   |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br>Annapolis  |                           | c. LENGTH OF STAY IN 1b<br>16 hrs.   |                                   |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br>Anne Arundel General Hospital  |                           | e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br>RURAL - Crownsville                                    |                                   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br>Irwin Karl STEPNEY  |                           | 4. DATE OF DEATH<br>Month Day Year<br>Sept. 10 19 61   |                                   |
| 5. SEX<br>Male   | 6. COLOR OR RACE<br>Negro | 7. MARRIED<br>NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>      | 8. DATE OF BIRTH<br>Sept. 9, 1961 |
| 9. AGE (In years last birthday)<br>yrs. Months Days<br>16 38   |                           | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |                                   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |                           | 10b. KIND OF BUSINESS OR INDUSTRY  |                                   |
| 11. BIRTHPLACE (County & State, or foreign country)<br>Maryland  |                           | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.   |                                   |
| 13. FATHER'S NAME<br>John Henry Stepney  |                           | 14. MOTHER'S MAIDEN NAME<br>Shirley Geraldine Williamson   |                                   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)  |                           | 17. INFORMANT<br>Hospital records  |                                   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br>776X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO (b)<br>DUE TO (c) |                           | INTERVAL BETWEEN ONSET AND DEATH   |                                   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |                           | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. p.m.<br>19  |                           | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>                                  |                                   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                           | 20f. (City or town) (County) (State)   |                                   |
| 21. I certify that (I) <del>this hospital</del> attended the deceased from Sept. 9, 1961 to Sept. 10, 1961 that (I) <del>was</del> last saw the deceased alive on Sept. 10, 1961, and that death occurred at 9:30 AM, from the causes and on the date stated above.          |                           |  |                                   |
| 22a. SIGNATURE<br>Dr. R. L. Richardson   |                           | 22b. DATE SIGNED<br>9:30 AM  |                                   |
| 22c. PHYSICIAN'S NAME (Type)<br>Dr. R. L. Richardson   |                           | 22d. ADDRESS<br>110 Clay St., Annapolis, Md.   |                                   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |                           | 23b. DATE THEREOF<br>9-12-61   |                                   |
| 23c. NAME OF CEMETERY OR CREMATORY<br>Shiloh Memorial  |                           | 23d. LOCATION (City, town or county) (State)<br>Gambills, Md.  |                                   |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br>William Reese, Jr. - Annapolis, Md.  |                           | 25a. REC'D BY REGISTRAR<br>SEP 20 '61  |                                   |
| 25b. REGISTRAR'S SIGNATURE<br>Arthur E. Hanna  |                           |  |                                   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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| MARYLAND STATE DEPARTMENT OF HEALTH   |  |                                  |  |  |  |   |  |  |  |  |  |
|---|--|----------------------------------|--|--|--|---|--|--|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |                                  |  |  |  |   |  |  |  |  |  |
| CERTIFICATE OF DEATH  |  |                                  |  |  |  |   |  |  |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Anne Arundel</b> <b>MARYLAND</b>   |  |                                  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>e. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>          |  |   |  |  |  |  |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis</b>  |  |                                  |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>X RURAL - Annapolis</b>   |  |   |  |  |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>Anne Arundel General Hospital</b>  |  |                                  |  | d. STREET ADDRESS<br><b>85 Bay Drive, Bay Ridge</b>  |  |   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Anna</b> <b>Z</b> <b>STINCHCOMB</b>  |  |                                  |  | 4. DATE OF DEATH<br><b>Sept.</b> <b>5</b> <b>1961.</b>   |  |   |  |  |  |  |  |
| 5. SEX<br><b>Female</b>   |  | 6. COLOR OR RACE<br><b>White</b> |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>May 23, 1891</b> |  | 9. AGE (In years last birthday)<br><b>70</b> yrs.  |  | IF UNDER 1 YEAR<br>Months Days Hours Min.                            |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>TEACHER</b>   |  |                                  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>PUBLIC SCHOOLS</b>   |  |   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Maryland</b>                         |  |  |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |  |                                  |  | 13. FATHER'S NAME<br><b>Wm Zang</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>AMELIA SIEGERT</b>  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>no</b>  |  |                                  |  | 16. SOCIAL SECURITY NO.<br><b>no</b>   |  |   |  | 17. INFORMANT<br><b>MRS BERT HALTERMAN #2</b>  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Broncho pneumonia</b><br><b>194X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Myroid carcinoma c metastases</b><br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertension and coronary disease</b> |  |                                  |  |  |  |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>24 hours</b><br><b>1 year</b> |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |                                  |  |  |  |   |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                                  |  |  |  |   |  |  |  |  |  |
| 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)   |  |                                  |  |  |  |   |  |  |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |  |                                  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  |   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                         |  |  |  |
| 20f. (City or town)   |  |                                  |  | (County)   |  |   |  | (State)  |  |  |  |
| 21. I certify that (I) <del>100 percent</del> attended the deceased from <b>Sept. 5, 1961</b> to <b>Sept. 5, 1961</b> , that (I) <del>100</del> last saw the deceased alive on <b>Sept. 5, 1961</b> , and that death occurred at <b>Sept. 5, 1961</b> , from the causes and on the date stated above.   |  |                                  |  |  |  |   |  |  |  |  |  |
| 22a. SIGNATURE<br><b>Gerard Church</b>  |  |                                  |  | 22b. DATE SIGNED<br><b>3:15 PM</b>   |  |   |  |  |  |  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>GERARD CHURCH</b>  |  |                                  |  | 22d. ADDRESS<br><b>121 Cathedral St., Annapolis, Md.</b>   |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |  |                                  |  | 23b. DATE THEREOF<br><b>9-8-1961</b>   |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Bluff Cem.</b>                                  |  |  |  |
| 23d. LOCATION (City, town, or county)<br><b>Annapolis</b>   |  |                                  |  | (State)<br><b>Md.</b>  |  |   |  |  |  |  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>John M. Taylor</b>   |  |                                  |  | 25a. REC'D BY REGISTRAR<br><b>SEP 8 '61</b>  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>   |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9857

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>AA Co</u> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Referred to as institution) a. STATE <u>MD</u> b. COUNTY <u>AA Co</u>                          |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shady side</u>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Shady side</u>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION  |  | d. STREET ADDRESS <u>1</u>   |  |
| 3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Swinburn</u> Last <u>Swinburn</u>  |  | 4. DATE OF DEATH 9-22-1961 19  |  |
| 5. SEX <u>Male</u>  | 6. COLOR OR RACE <u>White</u>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 8-28-1878 83 yrs.                             |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Storekeeper</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>   |  |
| 11. BIRTHPLACE (State or foreign country) <u>ENGLAND</u>  |  | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |  |
| 13. FATHER'S NAME <u>William Swinburn</u>   |  | 14. MOTHER'S MAIDEN NAME <u>Elizabeth ARMSTRONG</u>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)   |  | 16. SOCIAL SECURITY NO. <u>578-05-2591</u>   |  |
| 17. INFORMANT <u>CHRISTIANA SWINBURN</u>  |  | Address <u>Shady side Md</u>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u><br>332X DUE TO <u>Generalized arteriosclerosis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>—</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> |  |  | INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u><br><u>years</u> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. 19<br>p. m.  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                           |
| 21. I certify that I attended the deceased from <u>Jan 1</u> 19 <u>60</u> , to <u>Sept. 22</u> 19 <u>61</u> , that I last saw the deceased alive on <u>Sept. 20</u> 19 <u>61</u> , and that death occurred at <u>10 AM</u> , from the causes and on the date stated above.  |  |  |  |
| ACTUAL SIGNATURE <u>Willard F. Smith</u> M.D.   |  | ADDRESS (Street, city or town, state) <u>Shady Side, Md.</u> DATE SIGNED <u>9/24/61</u>  |  |
| PHYSICIAN'S NAME (Type) <u>—</u>  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)   | 22b. DATE THEREOF  | 22c. NAME OF CEMETERY OR CREMATORY   | 22d. LOCATION (City, town, or county) (State)                  |
| <u>BURIAL</u>   | <u>SEPT 25 1961</u>  | <u>QUAKER</u>  | <u>Galesville Md</u>   |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>T A Hanchey + Son</u>   |  | 24a. REC'D BY REGISTRAR <u>SEP 27 '61</u>  | 24b. REGISTRAR'S SIGNATURE <u>—</u>                            |



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

9858

09847

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b><br>c. LENGTH OF STAY IN 1b <b>1 year 9 mos. 13 days</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Crownsville State Hospital</b> |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Baltimore City</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b><br>d. STREET ADDRESS <b>2554 Pennsylvania Ave.</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |
| 3. NAME OF DECEASED<br>(Type or print) <b>James Taylor</b>  |  |  |  | 4. DATE OF DEATH<br>Month <b>9</b> Day <b>1</b> Year <b>1961</b>   |  |   |  |
| 5. SEX <b>Male</b>  |  | 6. COLOR OR RACE <b>Negro</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 8. DATE OF BIRTH <b>January 25, 1914</b>                            |  |
| 9. AGE (In years last birthday) <b>47</b> yrs.  |  | IF UNDER 1 YEAR<br>Months <b>9</b> Days <b>1</b>   |  | IF UNDER 24 HRS.<br>Hours <b>1</b> Min.  |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>  |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>   |  | 11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b> |  |
| 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  |  |  |  |  |   |  |
| 13. FATHER'S NAME <b>Munfert Taylor</b>   |  |  |  | 14. MOTHER'S MAIDEN NAME <b>Hattie ?</b>   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>   |  | 16. SOCIAL SECURITY NO. <b>217-09-3488</b>   |  | 17. INFORMANT <b>Hospital Records</b>  |  | Address <b>Crownsville State Hospital</b>                           |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b><br>4344 DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <b>Acute Cardiac Dilatation</b><br>(c) DUE TO<br>(e), stating the underlying cause last.       |  |  |  |  |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Schizophrenic Reaction, Chronic Undifferentiated Type</b>   |  |  |  |  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>-----</b>   |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour e.m. <b>19</b><br>p.m.  |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>-----</b>   |  | 20f. (City or town) (County) (State)                                |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>11/3</b> , 19 <b>47</b> to <b>9/1</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>9/1</b> , 19 <b>61</b> , and that death occurred at <b>1:20 P.M.</b> from the causes and on the date stated above.                                      |  |  |  |  |  |   |  |
| 22a. SIGNATURE <b>Lionel McHenry Mapp, M. D.</b>  |  |  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |  | 22b. DATE SIGNED <b>9/1/61</b>                                      |  |
| 22c. PHYSICIAN'S NAME (Type) <b>Lionel McHenry Mapp, M. D.</b>  |  |  |  | 22d. ADDRESS <b>Crownsville State Hospital, Maryland</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |  | 23b. DATE THEREOF <b>Sept 6-1961</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>mt. auburn</b>   |  | 23d. LOCATION (City, town or county) (State) <b>Baltimore Md.</b>   |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <b>Earl Malmoe</b>   |  |  |  | ADDRESS <b>519 Mosher st.</b>  |  | 25a. REC'D BY REGISTRAR <b>SEP 5 '61</b>                            |  |
|   |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>                   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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James Arthur

Green Valley

Sept. 17, 1914

Green Valley State Hospital

James

Taylor

Henry

Male

January 22, 1914

Virginia

Inspector

Sanford Taylor

Little

Green Valley State Hospital

117-09-3683 Hospital Record

No

Infantry Corps

United States Marine Corps

California State Hospital, San Jose, California

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Green Valley State Hospital, Maryland

Local Police, No. 1

Sept 5, 1914

Sept 5, 1914

Green Valley State Hospital, Maryland



# 1 FOR STATE HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 9859 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Anne Arundel</b>  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution, give name and address)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>1877</b>                 |  | 09848   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Linthicum</b>   |  | c. LENGTH OF STAY IN 1b<br><b>Few instants.</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore</b>                              |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Baltimore-Washington Expressway</b>   |  | d. STREET ADDRESS<br><b>2008 Penrose Ave.</b>   |  | a. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                 |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Mae Frances Thomas</b>  |  | 4. DATE OF DEATH<br><b>Sept. 23rd. 1961</b>   |  | 5. SEX<br><b>F</b>  |  |
| 6. COLOR OR RACE<br><b>C.</b>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>Sept. 7, 1926</b>  |  |
| 9. AGE (In years last birthday)<br><b>35</b>   |  | IF UNDER 1 YEAR<br>Months Days Hours Min.   |  | IF UNDER 24 HRS.<br>Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>House wife</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Anne Arundel Co. Md.</b>  |  |
| 13. FATHER'S NAME<br><b>Joseph Gaither</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Esther Queen</b>   |  | 12. CITIZEN OF WHAT COUNTRY?  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)  |  | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br><b>Thurmon Thomas</b> Address <b>same</b>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Fracture of Skull. Fractures of both legs</b><br>DUE TO (b) <b>and multiple deep lacerations.</b><br>DUE TO (c) <b>825X</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).<br>19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>Automobile accident.</b>                                  |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m.<br><b>2:38 A.M. 9/23/61</b>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>Balt.-Washington Expressway, Linthicum, A.A. Md.</b> |  |
| 20f. (City or town)<br><b>Baltimore</b>  |  | 20g. (County)<br><b>MD.</b>   |  | 20h. (State)<br><b>MD.</b>  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |  |   |  |
| ACTUAL SIGNATURE<br><b>Gustave H. Faubert, M.D.</b>  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> 9/24/61 DATE SIGNED   |  |
| EXAMINER'S NAME (Type)<br><b>Gustave H. Faubert, M.D.</b>  |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |  | Glen Burnie, Md.  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 22b. DATE THEREOF<br><b>9-27-61</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore National</b>   |  |
| 22d. LOCATION (City, town, or country)<br><b>Baltimore Md.</b>   |  | 22e. REC'D BY REGISTRAR<br><b>SEP 26 '61</b>  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Phillips</b>   |  |
| 23. FUNERAL DIRECTOR<br><b>Arlington S. Phillips</b>   |  | ADDRESS<br><b>1808 N. Monroe St.</b>  |  | 24a. DATE   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
9860  
CERTIFICATE OF DEATH

|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Anne Arundel</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Crownsville</b><br>c. LENGTH OF STAY in 1b<br><b>5 years 6 mos. 18 days</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>Crownsville State Hospital</b> |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institutional, give date of admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Baltimore City</b><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore</b><br>d. STREET ADDRESS<br><b>613 Cheraton Road</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Mary</b><br><b>Etta</b><br><b>Thomas</b>  |  | 4. DATE OF DEATH<br>Month<br><b>9</b><br>Day<br><b>7</b><br>Year<br><b>19 61</b>  |  | 5. SEX<br><b>Female</b><br>6. COLOR OR RACE<br><b>Negro</b><br>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Domestic</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>-----</b>   |  | 9. AGE (In years last birthday) yrs.<br><b>54</b><br>IF UNDER 1 YEAR<br>Months Days<br>IF UNDER 24 HRS.<br>Hours Min.  |  |  |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Maryland</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 13. FATHER'S NAME<br><b>Charles Smith</b>  |  |  |  |
| 14. MOTHER'S MAIDEN NAME<br><b>Sadie White</b>   |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)<br><b>Unknown</b>  |  | 16. SOCIAL SECURITY NO.<br><b>Unknown</b>  |  |  |  |
| 17. INFORMANT<br><b>Hospital Records - Crownsville State Hospital, Md.</b>   |  | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]<br>PART I. DEATH WAS CAUSED BY:<br><b>443X</b> IMMEDIATE CAUSE (a) <b>Hypertensive Cardio-Vascular Disease</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO (b)<br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)<br><b>Diabetes Mellitus</b> |  | INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>-----</b>  |  |  |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. -----<br>p.m. -----<br><b>19</b>  |  | 20d. INJURY OCCURRED<br>While Not While<br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>-----</b>   |  |  |  |
| 20f. (City or town)<br><b>-----</b>  |  | 20g. (County)<br><b>-----</b>   |  | 20h. (State)<br><b>-----</b>   |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>6/15</b> to <b>9/7</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>9/7</b> , 19 <b>61</b> , and that death occurred at <b>5:20</b> P.M. from the causes and on the date stated above.  |  |   |  |  |  |  |  |
| 22a. SIGNATURE<br><b>L. Benedict, M. D.</b>  |  | 22b. DATE SIGNED<br><b>9/8/61</b>   |  | 22c. PHYSICIAN'S NAME (Type)<br><b>L. Benedict, M. D.</b>  |  |  |  |
| 22d. ADDRESS<br><b>Crownsville State Hospital, Maryland</b>  |  | 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |  |  |  |  |  |
| 23b. DATE THEREOF<br><b>9/12/61</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MT. CALVARY Cem.</b>   |  | 23d. LOCATION (City, town or county) (State)<br><b>BROOKLYN, Md.</b>   |  |  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>C. O. Wilson</b>  |  | ADDRESS<br><b>1000 Brantley Ave.</b>  |  | 25a. REC'D BY REGISTRAR<br><b>SEP 14 '61</b>   |  |  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Arthur E. Kneel</b>   |  |   |  |  |  |  |  |

3280

(M)

James Arthur

Wynne

Crownsville

born 18 yrs

Wilmington

Crownsville State Hospital

Old Chesapeake Road

Wife

Wife

Thomas

Female

March 28, 1907

24

Domestic

England

U.S.A.

Charles Smith

Edie White

Unknown

Unknown

Psychiatric Institute - Baltimore

Blindfolded

3/7 28 3/7 28

3/7 28

3/7 28

x

J. J. J. J.

Crownsville State Hospital, Maryland

Handwritten notes and signatures at the bottom of the page.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9861

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

98850

|  |                              |   |  |  |  |  |  |
|--|------------------------------|---|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>A.A. CO.</u> MARYLAND  |                              |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MD</u> b. COUNTY <u>ALLEN</u> |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>RURAL - ARDEN-ON-SEVERN</u>   |                              |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>BALTIMORE - MARYLAND</u>                    |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>TUDOR RD.</u>   |                              |   |  | d. STREET ADDRESS<br><u>31 S. COLHOUN ST.</u>  |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>John</u> Middle <u>P</u> Last <u>Tilenis</u>   |                              |   |  | 4. DATE OF DEATH<br>Month <u>9</u> Day <u>29</u> Year <u>1961</u>  |  |  |  |
| 5. SEX<br><u>M</u>   | 6. COLOR OR RACE<br><u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>6-2-1921</u>  |  | 9. AGE (In years last birthday)<br><u>40</u> yrs.            |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Att. State Hospt. Md. State Hospt.</u>   |                              | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>ILL.</u>  |  | 11. BIRTHPLACE (State or foreign country)<br><u>ILL.</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>                |  |
| 13. FATHER'S NAME<br><u>LEO TILLENIS</u>   |                              |   |  | 14. MOTHER'S MAIDEN NAME<br><u>"UNK"</u>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>YES</u>   |                              | 16. SOCIAL SECURITY NO.<br><u>WW II</u>   |  | 17. INFORMANT<br><u>MARY ANN TILLENIS</u>  |  | Address<br><u>#2</u>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Shin shot wound abdomen</u><br>976X DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) _____<br>(a), stating the underlying cause last. DUE TO (c) _____<br>INTERVAL BETWEEN ONSET AND DEATH<br><u>Sudden</u>  |                              |   |  |  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____  |                              |   |  |  |  |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>  |                              | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><u>Shin shot wound abdomen</u>                              |  |  |  |  |  |
| 20c. TIME OF INJURY<br>Hour <u>o. m.</u> Month, Day, Year <u>19</u>  |                              | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u>Home</u>  |  | 20f. (City or town) (County) (State)<br><u>ALLEN MD</u>      |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . |                              |   |  |  |  |  |  |
| ACTUAL SIGNATURE<br><u>John M. Taylor</u>  |                              |   |  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  | DATE SIGNED<br><u>9/29/61</u>                                |  |
| EXAMINER'S NAME (Type)<br><u>F. LINHART</u>  |                              |   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |  |  |
|  |                              |   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Removal 10-1-61</u>  |                              | 22b. DATE THEREOF<br><u>10-1-61</u>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Chicago</u>   |  | 22d. LOCATION (City, town, or county) (State)<br><u>Ill.</u> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>John M. Taylor Son Annapolis Md</u>   |                              |   |  | ADDRESS<br><u>Annapolis Md</u>   |  | 24a. REC'D BY REGISTRAR<br><u>DATE 3 '61</u>                 |  |
|  |                              |   |  | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur E. Hume</u>  |  |  |  |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. Prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
2861

|  |  |   |  |
|--|--|---|--|
| 1. NAME OF DECEASED<br>JAMES H. HARRIS     |  | 2. SEX<br>Male                                    |  |
| 3. AGE<br>65                               |  | 4. OCCUPATION<br>Retired                          |  |
| 5. PLACE OF BIRTH<br>Baltimore, Md.        |  | 6. DATE OF BIRTH<br>Jan 15, 1908                  |  |
| 7. PLACE OF DEATH<br>Baltimore, Md.        |  | 8. DATE OF DEATH<br>Jan 15, 1974                  |  |
| 9. CAUSE OF DEATH<br>Myocardial Infarction |  | 10. MANNER OF DEATH<br>Natural                    |  |
| 11. SIGNATURE OF PHYSICIAN<br>J. H. Harris |  | 12. SIGNATURE OF MEDICAL EXAMINER<br>J. H. Harris |  |
| 13. SIGNATURE OF WITNESS<br>J. H. Harris   |  | 14. SIGNATURE OF WITNESS<br>J. H. Harris          |  |
| 15. SIGNATURE OF WITNESS<br>J. H. Harris   |  | 16. SIGNATURE OF WITNESS<br>J. H. Harris          |  |
| 17. SIGNATURE OF WITNESS<br>J. H. Harris   |  | 18. SIGNATURE OF WITNESS<br>J. H. Harris          |  |
| 19. SIGNATURE OF WITNESS<br>J. H. Harris   |  | 20. SIGNATURE OF WITNESS<br>J. H. Harris          |  |
| 21. SIGNATURE OF WITNESS<br>J. H. Harris   |  | 22. SIGNATURE OF WITNESS<br>J. H. Harris          |  |
| 23. SIGNATURE OF WITNESS<br>J. H. Harris   |  | 24. SIGNATURE OF WITNESS<br>J. H. Harris          |  |
| 25. SIGNATURE OF WITNESS<br>J. H. Harris   |  | 26. SIGNATURE OF WITNESS<br>J. H. Harris          |  |
| 27. SIGNATURE OF WITNESS<br>J. H. Harris   |  | 28. SIGNATURE OF WITNESS<br>J. H. Harris          |  |
| 29. SIGNATURE OF WITNESS<br>J. H. Harris   |  | 30. SIGNATURE OF WITNESS<br>J. H. Harris          |  |
| 31. SIGNATURE OF WITNESS<br>J. H. Harris   |  | 32. SIGNATURE OF WITNESS<br>J. H. Harris          |  |
| 33. SIGNATURE OF WITNESS<br>J. H. Harris   |  | 34. SIGNATURE OF WITNESS<br>J. H. Harris          |  |
| 35. SIGNATURE OF WITNESS<br>J. H. Harris   |  | 36. SIGNATURE OF WITNESS<br>J. H. Harris          |  |
| 37. SIGNATURE OF WITNESS<br>J. H. Harris   |  | 38. SIGNATURE OF WITNESS<br>J. H. Harris          |  |
| 39. SIGNATURE OF WITNESS<br>J. H. Harris   |  | 40. SIGNATURE OF WITNESS<br>J. H. Harris          |  |
| 41. SIGNATURE OF WITNESS<br>J. H. Harris   |  | 42. SIGNATURE OF WITNESS<br>J. H. Harris          |  |
| 43. SIGNATURE OF WITNESS<br>J. H. Harris   |  | 44. SIGNATURE OF WITNESS<br>J. H. Harris          |  |
| 45. SIGNATURE OF WITNESS<br>J. H. Harris   |  | 46. SIGNATURE OF WITNESS<br>J. H. Harris          |  |
| 47. SIGNATURE OF WITNESS<br>J. H. Harris   |  | 48. SIGNATURE OF WITNESS<br>J. H. Harris          |  |
| 49. SIGNATURE OF WITNESS<br>J. H. Harris   |  | 50. SIGNATURE OF WITNESS<br>J. H. Harris          |  |
| 51. SIGNATURE OF WITNESS<br>J. H. Harris   |  | 52. SIGNATURE OF WITNESS<br>J. H. Harris          |  |
| 53. SIGNATURE OF WITNESS<br>J. H. Harris   |  | 54. SIGNATURE OF WITNESS<br>J. H. Harris          |  |
| 55. SIGNATURE OF WITNESS<br>J. H. Harris   |  | 56. SIGNATURE OF WITNESS<br>J. H. Harris          |  |
| 57. SIGNATURE OF WITNESS<br>J. H. Harris   |  | 58. SIGNATURE OF WITNESS<br>J. H. Harris          |  |
| 59. SIGNATURE OF WITNESS<br>J. H. Harris   |  | 60. SIGNATURE OF WITNESS<br>J. H. Harris          |  |
| 61. SIGNATURE OF WITNESS<br>J. H. Harris   |  | 62. SIGNATURE OF WITNESS<br>J. H. Harris          |  |
| 63. SIGNATURE OF WITNESS<br>J. H. Harris   |  | 64. SIGNATURE OF WITNESS<br>J. H. Harris          |  |
| 65. SIGNATURE OF WITNESS<br>J. H. Harris   |  | 66. SIGNATURE OF WITNESS<br>J. H. Harris          |  |
| 67. SIGNATURE OF WITNESS<br>J. H. Harris   |  | 68. SIGNATURE OF WITNESS<br>J. H. Harris          |  |
| 69. SIGNATURE OF WITNESS<br>J. H. Harris   |  | 70. SIGNATURE OF WITNESS<br>J. H. Harris          |  |
| 71. SIGNATURE OF WITNESS<br>J. H. Harris   |  | 72. SIGNATURE OF WITNESS<br>J. H. Harris          |  |
| 73. SIGNATURE OF WITNESS<br>J. H. Harris   |  | 74. SIGNATURE OF WITNESS<br>J. H. Harris          |  |
| 75. SIGNATURE OF WITNESS<br>J. H. Harris   |  | 76. SIGNATURE OF WITNESS<br>J. H. Harris          |  |
| 77. SIGNATURE OF WITNESS<br>J. H. Harris   |  | 78. SIGNATURE OF WITNESS<br>J. H. Harris          |  |
| 79. SIGNATURE OF WITNESS<br>J. H. Harris   |  | 80. SIGNATURE OF WITNESS<br>J. H. Harris          |  |
| 81. SIGNATURE OF WITNESS<br>J. H. Harris   |  | 82. SIGNATURE OF WITNESS<br>J. H. Harris          |  |
| 83. SIGNATURE OF WITNESS<br>J. H. Harris   |  | 84. SIGNATURE OF WITNESS<br>J. H. Harris          |  |
| 85. SIGNATURE OF WITNESS<br>J. H. Harris   |  | 86. SIGNATURE OF WITNESS<br>J. H. Harris          |  |
| 87. SIGNATURE OF WITNESS<br>J. H. Harris   |  | 88. SIGNATURE OF WITNESS<br>J. H. Harris          |  |
| 89. SIGNATURE OF WITNESS<br>J. H. Harris   |  | 90. SIGNATURE OF WITNESS<br>J. H. Harris          |  |
| 91. SIGNATURE OF WITNESS<br>J. H. Harris   |  | 92. SIGNATURE OF WITNESS<br>J. H. Harris          |  |
| 93. SIGNATURE OF WITNESS<br>J. H. Harris   |  | 94. SIGNATURE OF WITNESS<br>J. H. Harris          |  |
| 95. SIGNATURE OF WITNESS<br>J. H. Harris   |  | 96. SIGNATURE OF WITNESS<br>J. H. Harris          |  |
| 97. SIGNATURE OF WITNESS<br>J. H. Harris   |  | 98. SIGNATURE OF WITNESS<br>J. H. Harris          |  |
| 99. SIGNATURE OF WITNESS<br>J. H. Harris   |  | 100. SIGNATURE OF WITNESS<br>J. H. Harris         |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9862

## CERTIFICATE OF DEATH

09851

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Anne Arundel</u> <b>MARYLAND</b>  |  |  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution, state where before admission)<br>e. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>   |  |  |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>Annapolis</u>   |  |  |  | c. LENGTH OF STAY IN 1b<br><u>2 weeks</u>  |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><u>Anne Arundel General Hospital</u>   |  |  |  | d. STREET ADDRESS<br><u>102 Clay St.,</u>  |  |  |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  |  |  |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print)<br><u>Baby</u>   |  |  |  | <b>4. DATE OF DEATH</b><br>Month <u>Sept.</u> Day <u>3</u> Year <u>1961.</u>   |  |  |  |
| <b>5. SEX</b><br><u>Male</u>   |  |  |  | <b>6. COLOR OR RACE</b><br><u>Negro</u>  |  |  |  |
| <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>   |  |  |  | <b>8. DATE OF BIRTH</b><br><u>Aug. 20, 1961</u>  |  |  |  |
| <b>9. AGE</b> (In years last birthday) yrs. <u>14</u>  |  |  |  | <b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><u>None</u>   |  |  |  |
| <b>11. BIRTHPLACE</b> (County & State, or foreign country)<br><u>Maryland</u>  |  |  |  | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><u>U.S.</u>   |  |  |  |
| <b>13. FATHER'S NAME</b><br><u>David Ferrell</u>   |  |  |  | <b>14. MOTHER'S MAIDEN NAME</b><br><u>Maxine Tongue</u>  |  |  |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, No, or unknown) <u>No</u>   |  |  |  | <b>16. SOCIAL SECURITY NO.</b><br><u>Maxine Tongue - Annapolis, Md.</u>  |  |  |  |
| <b>17. INFORMANT</b><br><u>Maxine Tongue</u>   |  |  |  | <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Prematurity (Birth wt. 2 lb 4 3/4 oz.)</u><br>Conditions, if any, which gave rise to immediate cause (b) <u>776 X</u><br>(a), stating the underlying cause last. (c) <u>Since birth</u> |  |  |  |
| <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>   |  |  |  | <b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| <b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <input type="checkbox"/>   |  |  |  | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |
| <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour a.m. <u>19</u> p.m.  |  |  |  | <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  |  |  |
| <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)  |  |  |  | <b>20f. (City or town) (County) (State)</b>  |  |  |  |
| <b>21. I certify that (I) (Incumbent) attended the deceased from Aug. 20, 1961 to Sept. 2, 1961, that (I) (X) saw the deceased alive on Sept. 3, 1961, and that death occurred at 4:45 AM, from the causes and on the date stated above.</b> |  |  |  | <b>22a. SIGNATURE</b><br><u>Raymond P. Srsic</u> M.D. <b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> <b>DATE</b> <u>9-5-61</u>   |  |  |  |
| <b>22c. PHYSICIAN'S NAME (Type)</b><br><u>Raymond P. Srsic</u>   |  |  |  | <b>22d. ADDRESS</b><br><u>Medical Bldg., Severna Park, Md.</u>   |  |  |  |
| <b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b><br><u>Burial</u>  |  |  |  | <b>23b. DATE THEREOF</b><br><u>9-5-61</u>  |  |  |  |
| <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><u>Brewer Hill</u>  |  |  |  | <b>23d. LOCATION (City, town or county) (State)</b><br><u>Annapolis, Md.</u>   |  |  |  |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b><br><u>William Geese, Jr. Annap. Md.</u>  |  |  |  | <b>25a. RECEIVED BY REGISTRAR</b><br><u>SEP 11 1961</u>  |  |  |  |
| <b>25b. REGISTRAR'S SIGNATURE</b><br><u>Arthur S. Kraus</u>  |  |  |  |  |  |  |  |

03823

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State of Ohio

Attorney General

John S. Smith

Amesbury

John S. Smith, Attorney General

John S. Smith, Attorney General

Amesbury

Amesbury, Mass.

Amesbury

Amesbury

Amesbury, Mass. 1882

Amesbury, Mass. 1882

Amesbury, Mass. 1882

Amesbury, Mass. 1882





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

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FOR STATE  
HEALTH DEPT.

(M)

(I)

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |   |  |   |  |   |  |  |  |   |  |  |  |  |
|--|--|---|--|---|--|---|--|--|--|---|--|--|--|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |   |  |   |  |   |  |  |  |   |  |  |  |  |
| 9864 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09853   |  |   |  |   |  |   |  |  |  |   |  |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>AA CO.</u> <u>MARYLAND</u>   |  |   |  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>a. STATE <u>MD</u> b. COUNTY <u>AA CO.</u>                      |   |  |  |  |   |  |  |  |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>RURAL</u>   |  |   |  |   | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>X Arnold- Maryland.</u>   |   |  |  |  |   |  |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><u>000- ANNE ARUNDEL general.</u>  |  |   |  |   | d. STREET ADDRESS<br><u>1 Shore Acres.</u>   |   |  |  |  |   |  |  |  |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |   |  |   |  |  |  |   |  |  |  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br><u>Edward W. Wendt</u>  |  |   |  |   | 4. DATE OF DEATH<br>Month Day Year<br><u>9 30 1961</u>   |   |  |  |  |   |  |  |  |  |
| 5. SEX<br><u>M</u>   |  | 6. COLOR OR RACE<br><u>W</u>                        |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>2-2-1944</u>         |  | 9. AGE (In years last birthday)<br><u>17</u> |  |   |  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>STUDENT</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>STUDENT</u> |  | 11. BIRTHPLACE (State or foreign country)<br><u>MARYLAND</u>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.</u> |  |  |  |   |  |  |  |  |
| 13. FATHER'S NAME<br><u>GEORGE WENDT</u>   |  |   |  |   | 14. MOTHER'S MAIDEN NAME<br><u>MARGARET Fick</u>   |   |  |  |  |   |  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give year or dates of service)<br><u>NO</u>   |  |   |  |   | 16. SOCIAL SECURITY NO.<br><u>-</u>  |   |  |  |  | 17. INFORMANT<br><u>GEORGE WENDT #2</u>   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Gun shot wound thorax</u><br>919.0 DUE TO<br>Conditions, if any, which gave rise to immediate cause (b)<br>(c) DUE TO<br>(e), stating the underlying cause last.<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)<br>19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |   |  |   |  |  |  |   |  |  |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.  |  |   |  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><u>Joseph Lomax stumbled + gun accidentally went off</u> |   |  |  |  |   |  |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br><u>1.30 a.m. 9/30 1961</u>  |  |   |  |   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>                                     |   |  |  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u>Home</u> |  |  |  |  |
| 20f. (City or town)<br><u>AA CO.</u>   |  |   |  |   | 20g. (State)<br><u>MD.</u>   |   |  |  |  |   |  |  |  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  |  |   |  |   |  |   |  |  |  |   |  |  |  |  |
| ACTUAL SIGNATURE<br><u>E. Lichardt</u>   |  |   |  |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |   |  |  |  | DATE SIGNED<br><u>9/31/61</u>   |  |  |  |  |
| EXAMINER'S NAME (Type)<br><u>E. Lichardt</u>   |  |   |  |   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |   |  |  |  | Address (Street, city, town, or county)<br><u>9/31/61</u>                             |  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>   |  |   |  |   | 22b. DATE THEREOF<br><u>10-3-61</u>  |   |  |  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>GLEN HAVEN</u>                               |  |  |  |  |
| 22d. LOCATION (City, town, or country)<br><u>GLEN BURNIE MD.</u>   |  |   |  |   | 22e. (State)<br><u>MD.</u>   |   |  |  |  |   |  |  |  |  |
| 23. FUNERAL DIRECTOR<br><u>John M. Lyton + Sons Annapolis, Md.</u>   |  |   |  |   | 24a. REC'D BY REGISTRAR<br>DATE <u>OCT 3 '61</u>   |   |  |  |  | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur L. House</u>                                  |  |  |  |  |

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